PSYCHIATRY NOTES

For Medical Students

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بِسْمِ اللَّهِ الرَّحْمَٰنِ الرَّحِيمِ

Hello my colleagues,
Let me to present to you “**PSYCHIATRY NOTES For Medical Students”**
,which presents the topics of Psychiatry Medicine in a new and practical way.
I would like to note that I have prepared a part of it during my personal study before the final exam; As for the larger part, I completed it after the exam.
I would like to confirm that I prepared and compiled it from different sources that I mentioned in the references at the end of the book, and my goal was to help you find one book in which easy for you to access the information in an easy and interesting way.
In this book you will find the most important topics that may be scattered in other books and references, I arranged, coordinated and presented them in the way I thought was the best.
I think that the study is completed when you read the topic well and then try to solve questions on it, so; I allocated a large number of questions, and I put a short test at the end, which I hope that all of you will succeed in answering it.
I would like to emphasize that this book is not a substitute for doctors' materials, references or clinical round.
Finally, “Perfection Is For Allah”; you may find errors in this book, please send to me for that.
I wish you success Insha'Allah and that you get the maximum benefit possible from this book.
My sincere love and respect.

Mosab Emad Mubayed
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2022

Contents

According to chapters:

According to topics:

Chapter One

Psychopathology

بسم الله الرحمن الرحيم

Psychopathology

1. Consciousness 2. Perception 3. Thinking 4. Memory 5. Mood 6. Motor 7. intelligence

WHAT IS PSYCHIATRY??

An area of medicine involving the study, diagnosis and treatment of mental health disorders.

WHAT IS PSYCHOPATHOLOGY ??

Systematic study of abnormal experience, cognition and behavior.
The study of the products of a disordered mind.

❖ **Note**: **Psychopathology is the language of Psychiatry**; so any term you will find in this chapter is very important for understanding psychiatric disorders.

❖ Definitions:

1. Consciousness: a state of **awareness** of the self and environment.

2. Perception: a process by which individuals **organize and interpret their sensory impressions** in order to give meaning to their environment.

3. Hallucinations: a **false perception** which is not a sensory distortion or a misinterpretation, but which occurs at the same time as real perceptions, in the **absence of external stimuli.**

4. Delusions: a **fixed, unshakeable belief** that is out of keeping with the patient's social and cultural background.

5. Sensory memory: is registered for each of the senses and its purpose is to facilitate the **rapid processing of incoming stimuli** so that comparisons can be made with material already stored in short- and long-term memory.

6. Short-term memory = working memory:
allows for the **storage of memories for much longer than the few seconds** available to sensory memory, constant updating of one's surroundings.

7. Amnesia: partial or total **inability to recall past experiences** and its origin may be organic or psychogenic.

8. Hypermnesia "hyperthymesia": an **extreme degree of retentiveness and recall**, with unusual clarity of memory images.

9. Feeling: a **positive or negative** reaction to some experience or event and is the subjective experience of emotion.

10. Emotion: **stirred-up state** caused by physiological changes occurring as a **response to some event** and which tends to maintain or abolish the causative event.

11. Mood: a **pervasive and sustained emotion** that colours the person's perception of the world.

12. Affect: **short-lived emotion**, is the patient's present emotional responsiveness.

13. Intelligence: the **ability to think and act rationally and logically**.

Psychopathology

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1. Consciousness

Restriction = loss

awareness is narrowed down to a few ideas and attitudes that dominate the patient's mind.

Lowering of consciousness

* psychologically **benumbed**
* general lowering of consciousness
* **without** hallucinations, illusions, delusions and restlessness

Dream like changes

* **some lowering** of the level of consciousness
* rise in the threshold for all incoming stimuli
* disoriented for time and place, **but not for person**

2. Perception

Intensity abnormalities → *** hyper- or hypo-aesthesia**
* Anxious and manic patients perceive noise as very loud while depressed patient less intense.

Quality abnormalities ← * Mainly visual perceptions that are affected by this, brought about by toxic substances.
* Schizophrenic patient report that food tastes unpleasant.

Illusions

Stimuli from a perceived object are combined with a mental image to produce a **false perception**.

Hallucinations

1. Hypnagogic
while falling asleep

2. Hypnopompic
while awaking from sleep

3. Pseudo Hallucinations
as a hallucination, but which is recognized by the patient it as unreal

Hallucinations of individual senses : **Auditory** ,**Visual**, Smell, Taste, Touch, Pain and deep sensations

Depersonalization

Person feels unreal

Derealization

Change in self awareness such that the environment feels, unreal.

Dysmegalopsia

change in the shape of an object

Micropsia
smaller than they really

Macropsia or Megalopsia.

Psychopathology

3. Thinking

A- Disorders of **Stream** of thoughts

❖ **Disorders of Continuity:**

1. **Perseveration**: persistent inappropriate repetition of the same thought, the patient gives the correct answer to the first question but continues to give the same answer for different questions.
2. **Thought blocking**: sudden arrest of the train of thought, leaving a blank.
3. **Dysphasia**: receptive or expressive.
4. **Dysarthria**: difficulty in articulation.

❖ **Disorders of Tempo:**

1. **Pressure of thought**: rapid, abundant thoughts.
2. **Flight of ideas**: thoughts follow each other rapidly; no general direction of thinking; usually understood.
3. **Inhibition/retardation of thinking**: the train of thought is slowed down and the number of ideas and mental images that present themselves is decreased.
4. **Circumstantiality**: thinking proceeds slowly with many unnecessary and trivial details, **but finally the point is reached**.

B- Disorders of **Form** of thoughts

1. **Loosening of association:** loss of the normal structure, no links between ideas.
2. **Neologisms:** words created by patient.
3. **Echolalia:** repetition by the patient of the interviewer's word.

C- Disorders of **Possession**

1. **Thought insertion**: thoughts inserted by an outside agency, recognize them as being foreign and coming from without.
2. **Thought withdrawal**: thoughts have been taken out of mind.
3. **Thought broadcasting**: unspoken thoughts are known to other people through radio or TV.

Psychopathology

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Continue.. Thinking

D- Disorder of **Content**

1. Overvalued ideas:

An isolated preoccupying strongly held belief which **dominates the person's life** and may affect his actions, neither delusional nor obsessional in nature.

2. Obsessions:

- Recurrent, persistent & senseless thoughts, images or impulses that appear against the patients will and unsuccessfully resisted and recognized by the patient as his own
- Seen in **Obsessions and compulsions disorder:**

➢ An **obsession** (also termed a rumination) is a thought that persists and dominates an individual's thinking despite the individual's awareness that the thought is either entirely without purpose or else has persisted and dominated their thinking beyond the point of relevance or usefulness.

➢ **Compulsions** are, in fact, merely obsessional motor acts. They may result from an obsessional impulse that leads directly to the action, or they may be mediated by an obsessional mental image or though

3. Delusions

❖ **Primary delusions "True":**

- Primary delusional experience, not related to another morbid phenomenon.
- **Schneider** suggested that these experiences can be reduced to three forms of primary delusional experience:
  - **Delusional mood:** the patient has the knowledge that there is something going on around him that concerns him, but he does not know what it is.
  - **Delusional perception:** the attribution of a new meaning, usually in the sense of self-reference, to a normally perceived object.
  - **Sudden delusional idea:** delusion appears fully formed in the patient's mind. This is sometimes known as an autochthonous delusion.

❖ **Secondary delusions "delusion like idea"**

- Derived from some other morbid psychological phenomenon.
- **Types**: Delusions of Persecution, Infidelity (morbid jealousy), love (love famous character), Grandiose, Ill health, Guilt, Poverty and **Nihilistic**.

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4. Memory

Amnesias

1. **Anterograde amnesia.**
2. **Retrograde amnesia.**
3. **Psychogenic amnesias.**
4. **Dissociative/hysterical amnesia:** sudden amnesia, during periods of extreme trauma and can last for hours or

Note:
The amnesia will be for **personal identity** such as name, address and history as well as for personal events, while at the same time the **ability to perform complex behaviors is maintained**.

Hypermnesia

Flashbacks are sudden intrusive memories that are associated with the cognitive and emotional experiences of a traumatic event such as an accident.

Flashbulb memories memories that are associated with intense emotion. They are unusually vivid, detailed and long-lasting.

Confabulation

It manifests itself as the **filling-in of gaps** in memory by imagined or untrue experiences that have **no basis in fact**.

Pseudo logia fantastica

confabulation that occurs in those **without organic brain pathology** such as personality disorder of antisocial or hysterical type. Also called: fluent plausible lying (pathological lying)

Disorder of **Recognition**

- **Déjà vu:** Problem with the familiarity of places and events. It comprises **the feeling of having experienced a current event in the past**, although it has no basis in fact.
- **Jamais vu:** The knowledge that an **event has been experienced before** but is not presently associated with the appropriate feelings of familiarity.
- **Déjà entendu**: The feeling of auditory recognition.
- **Déjà pense**: A new thought recognized as **having previously occurred**, are related to déjà vu, being different only in the modality of experience.

Psychopathology

5. Mood

A) Abnormalities of nature (quality) of mood

- **Depression**: pathological feeling of sadness, pervasive lowering of mood and inability to experience Pleasure "anhedonia".
- **Anxiety**: feeling of apprehension which is out of proportion to the actual situation.
- **Elation**: pervasive rising of the mood accompanied by excessive cheerfulness.
- **Euphoria**: a state of excessive unreasonable cheerfulness and unconcern.
- **Lability**: easily provoked to anger with liability to out burst.
- **Ambivalence**: coexistence of two opposite feelings directed towards the same person at the same time.
- **Dysphoria**: unpleasant mood.
- **Apathy**: loss of affect or absence of feeling often associated with detachment. It is the extreme form of loss of emotions.

B) Abnormalities of expression of mood

- **Incongruity:** incongruous inappropriate mood is that which is not keeping with that would normally be expected.
- **Blunting (flatting):** insensitivity to emotions of others i.e. sustained emotional indifference, reduced rather than lost affect.
- **La belle indifference:** denial of affect "conversion reaction" Hysteria.

C) Abnormalities of constancy (fluctuation) of mood

- **Emotional lability:** rapid abrupt changes in emotions unrelated to external stimuli.
- **Emotional incontinence:** extreme form of emotional lability with complete loss of control over emotion, (brain stem lesion).

Psychopathology

6. Motor

A) Disorders of movement

Increased movement

1. Hyperactivity: increased motor activity usually with talkativeness as in mania, or impulsivity as in ADHD.
2. Agitation: motor restlessness with increased arousal

Decreased movement

1. Immobility or akinesia: no voluntary movement at all as in depressive or catatonic stupor.
2. Psychomotor retardation: slowness of initiation, execution & completion of movement

B) Abnormal quality and form of movement

- **Mannerism**: abnormal repetitive goal-directed movement.
- **Stereotypy**: abnormal repetitive non-goal-directed movement i.e. purposeless.
- **Tics**: sudden, irregular, repetitive movement involving a group of muscles as in encephalitis.
- **Compulsion**: uncontrollable impulse to perform an act repetitively e.g. checking or washing.
- **Tremors**: static tremors of head or hands as in anxiety or drug induced.
- **Dystonia**: uncontrolled muscle spasm leading to involuntary movements of the **eye lid, face, neck, jaw, shoulders, larynx & hands** e.g. tongue protrusion, torticollis & oculogyric crisis as in drug included.
- **Akathisia**: inability to sit still with a need to get up & move about.
- **Tardive dyskinesia**: repetitive purposeless movement of the **facial muscles, mouth and tongue** as in drug induced.
- **Somnambulism**: walking and carrying out complex activities while asleep.
- **Perseveration**: senseless repetition of a previously requested movement.

Psychopathology

Continue.. Motor

B) Abnormal quality and form of movement

Catatonia

Very important topic, see page 71

Catatonia is state of **increased muscle tone at rest.**

Catatonic symptoms and signs seen in **catatonic schizophrenia** include:

- **Negativism**: resistance to command and attempts to be moved.
- **Echopraxia**: automatic imitation by the patient of the interviewer
- **Echolalia**: repetition by the patient of the interviewer's word.
- **Ambitendence**: patient begins to make a movement but before completing it starts opposite movement.
- **Psychological pillow**: Lying in the dorsal position with head elevated as if there was an invisible pillow under it.
- **Automatic obedience**: the patient does whatever is asked irrespective of the consequences.
- **Catalepsy or posturing**: the patient takes up and uncomfortable posture and maintains it with immobility for long period.
- **Waxy flexibility**: the patient limb can be bending and placed in awkward posture with a feeling of plastic resistance.

7. Intelligence

Dementia is **a loss of intelligence resulting from brain disease**. characterized by → disturbances of multiple cortical functions including: thinking, memory, comprehension and orientation, among others.

"See page 61"

Psychopathology

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Practical applications of Psychopathology:

Auditory hallucinations → Schizophrenia
Visual hallucinations → Schizophrenia, **alcohol withdrawal** and delirium
Touch hallucinations → addiction
Olfactory hallucination → temporal lobe epilepsy
Pressure of thought → Mania
Flight of ideas → Mania
Inhibition or retardation of thinking → Depression
Perseveration → Dementia
Loosening of association → Schizophrenia
Grandiose delusions → Mania
Delusions of guilt → Depression
Nihilistic delusions → Depression
Delusions of poverty → Depression
Obsessions → Obsessive-Compulsive disorder
Confabulation → Alcohol & Dementia
Pseudo logia fantastica → Anti-social personality disorder
Hypermnesia → PTSD
Elation → Mania
Euphoria → Mania
Emotional lability → Mania
Hyperactivity → Mania & ADHD
Agitation →Anxiety & Depression
Psychomotor retardation → Depression
Mannerism → Schizophrenia
Stereotypy → Schizophrenia
Tremors → Drug as Lithium
Dystonia → Drug as 1st generation antipsychotics: Haloperidol
Akathisia → Drug as 1st generation antipsychotics
Tardive dyskinesia → Drug as 1st generation antipsychotics
Perseveration → Dementia
Catatonia → Schizophrenia

Chapter Two

Psychopharmacology & Psychotherapy

بسم الله الرحمن الرحيم

Psychopharmacology

Antidepressants - Antipsychotics - Mood stabilizers - Anxiolytics

1. Antidepressants

Types	Full Name	Examples
TCAs	**Tricyclic Antidepressants**	Desipramine, nortriptyline, **Amitriptyline**, **imipramine**, clomipramine ,doxepin
MAOIs	**Monoamine oxidase inhibitors**	Non selective (tranylcypromine, phenelzine, isocarboxazid) Selective : selegiline
SSRIs	**Selective serotonin reuptake inhibitors**	**Fluoxetine**, **Sertraline**, **Citalopram**, Paroxetine, Escitalopram, Fluvoxamine
SNRIs	**Serotonin Norepinephrine reuptake inhibitors**	Venlafaxine, Desvenlafaxine, Duloxetine, Milnacipran, Levomilnacipran
	Atypical Antidepressants	Bupropion

Important Notes:

* **General SEFs →Antihistamine** : dry mouth, sedation, **NE blockade**: hypotension and **Muscarinic blockade**: tachycardia, urinary retention.
* Overdose of TCAs result in **hypotension** and that is the major cause of death here.
* Overdose of TCAs also result in **Prolongation of QT interval** lead to arrhythmia treated with $NaHCO_3$.
* Another uses of TCAs: OCD, Diabetic peripheral neuropathy, Chronic pain, Prevention of migraine headache, Bed wetting and Insomnia.
* **Serotonin Syndrome** can develop if take MAOI with drugs that increase serotonin.
* **Serotonin syndrome** symptoms: abdominal pain, diarrhea, sweats, tachycardia, HTN, myoclonus, irritability, delirium. Can lead to hyperpyrexia, cardiovascular shock and death.
* SSRI result in : **sexual dysfunction**, Decrease libido, Anorgasmia, Erectile dysfunction.
  So →SSRIs can treat premature ejaculation.
* SSRIs result in **Discontinuation syndrome** :Abrupt discontinuation of antidepressants Characterized by →Dizziness, fatigue, headache and nausea.
* SSRIs used in **Bulimia** nervosa ttt.
* SSRIs also result in QT prolongation and serotonin syndrome.
* **Selegiline used in Parkinson's disease**.
* Atypical antidepressant (Bupropion) used in **smoking cessation**.

Psychopharmacology

2. Antipsychotics

antipsychotics	First generation	Second generation
Examples	**HIGH Potency:** **Haloperidol**, Fluphenazine, Pimozide **LOW Potency:** **Chlorpromazine, Thioridazine**	**Clozapine** , **Olanzapine** , **Quetiapine**, Asenapine, Iloperidone, Paliperidone , **Risperidone**, Lurasidone, Ziprasidone
Main problems (SEFs)	* **Extrapyramidal symptoms (EPS)** See below * **Neuroleptic malignant syndrome** * **Prolonged QT interval** * **Retinal & Corneal deposits** (low potency)	* **Metabolic syndrome** = weight gain, hyperglycemia, hyperlipidemia * **Prolonged QT interval**

Important Notes:

* **Antipsychotics block dopamine →SEFs : Parkinson effects, Hyperprolactinemia, Gynecomastia, Galactorrhea, Amenorrhea and Antiemetic.**
* Other SEFs → **Acetylcholine (muscarinic) blockade**: Dry mouth, Constipation, Urinary retention , Tachycardia and Sexual dysfunction, **Epinephrine (alpha 1) blockade** : Hypotension, **Histamine blockade**: Weight gain and sedation

EPS	Dystonia	Akathisia	Bradykinesia	Tardive dyskinesia
What is it ?	Involuntary muscle contraction lead to spasm and stiffness	restlessness, urge to move	Slow movement like Parkinson	* Choreathetosis: it is seen in mouth, tongue, face and limbs * smacking lips and grimacing
treatment	**Antihistamine: Diphenhydramine**	benzodiazepine and propranolol	Anticholinergic : Benztropine	**valbenazine**

*** Neuroleptic malignant syndrome**:
rare dangerous reaction to **high potency first generation antipsychotics.**
Presentation → Fever and rigid muscles, Mental status changes "encephalopathy", Elevated creatinine kinase "muscle damage" and Myoglobinuria due to acute renal failure "rhabdomyolysis".
Treatment→ Muscle relaxant and Dopamine agonist: **bromocriptine**
* LOW potency result in : **Retinal deposit** → retinitis pigmentosa & browning of vision.
Also **Corneal deposit** → **cataract.**
* Chlorpromazine specific SEFs; **skin pigmentation & Cholestatic jaundice.**

* Rapid Notes:

1. **Quetiapine** has lowest risk of extrapyramidal side effects.
2. **Risperidone** has highest risk extrapyramidal side effects.
3. Prolonged QT interval has strongest association with **IV haloperidol.**
4. Ziprasidone is the highest risk of prolonged QT interval.
5. **Clozapine** associated with **Agranulocytosis**, Seizures and Myocarditis.

*** Long acting antipsychotics (Depot injection):** Use in poor compliance and resistance SZP.
Examples→ Flupenthixsol decanoate, Fluphenazine decanoate, Zuclopenthioxol Decanoate and Haloperidol Decanoate.
* Antipsychotics are the most common drug induced **hyperprolactinemia** → as Haloperidol.

Psychopharmacology

3. Mood Stabilizers

Mood stabilizer	Lithium	Valproic acid	Carbamazepine
Main use	**First medical therapy for bipolar disorders**	as Lithium in **mania prophylaxis**	1st line for **acute mania** & **mania prophylaxis**
Note	Only medication to reduce suicide rate	not as lithium effective in depression prophylaxis	Indicated for rapid cyclers and mixed patients
SEFs	**Tremor**, Confusion, Seizure , **Nausea, vomiting , diarrhea**, **Hypothyroidism** Hyperparathyroidism hypercalcemia Polyuria & polydipsia bradycardia Mild leukocytosis	Thrombocytopenia Nausea, vomiting, weight gain, Transaminitis, Sedation, tremor, hair loss and Increased risk of neural tube defect	**Rash**, Nausea, vomiting, diarrhea, transaminitis ,Sedation, dizziness, ataxia, confusion ,AV conduction delays ,Aplastic anemia ,agranulocytosis Water retention
Before use it	baseline creatinine, TSH, CBC and pregnancy test	LFTs, CBC and pregnancy test	LFTs, CBC and EKG
Steady state achieved after	5 days	4-5 days	5 days
Target	blood level between 0.6-1.2	between 50-125	4-12mcg/ml

Important Notes:

* **Most common lithium SEFs are** GI distress including reduced appetite, nausea/vomiting, diarrhea.
* **Lithium contraindicated** in patients with renal failure, pregnancy, cardiac arrhythmias, severe vomiting and diarrhea.
* **Lithium can cause Ebestin anomaly** because of its teratogenicity.
* **Lithium drug interaction**: Thiazide diuretic, ACE inhibitor, NSAIDs, Metronidazole, Tetracycline.
* Valproic acid better tolerated than Lithium.
* Tremor is the most common symptoms of **lithium toxicity** → ttt : propanol.

Lithium toxicity	at	Symptoms
Mild	1.5 – 2	vomiting, diarrhea, ataxia, dizziness, slurred speech, nystagmus
Moderate	2 – 2.5	nausea, vomiting, anorexia, blurred vision, clonic limb movements, convulsions, delirium, syncope
Severe	> 2.5	generalized convulsions, oliguria and renal failure

Psychopharmacology

4.Anxiolytics

❖ **Example**: **Benzodiazepine, Buspirone**

❖ **Used to treat**:

1. panic disorder
2. generalized Anxiety disorder
3. substance-related disorders and their withdrawal
4. insomnias and parasomnias
5. Brief psychotic event
6. Acute symptoms of acute stress disorder

❖ In anxiety disorders often use anxiolytics in combination with SSRIS or SNRIs for treatment.

HIGHLIGHT "1"

❖**Prolongation of QT interval** → Overdose of TCAs, SSRIs, haloperidol & Ziprasidone
❖ SSRIs can treat premature ejaculation and Bulimia nervosa.
❖ Bupropion used in smoking cessation.
❖ Selegiline used in Parkinson's disease.
❖ **Serotonin syndrome, Neuroleptic malignant syndrome and Extrapyramidal symptoms** are very important.
❖**Clozapine** associated with **Agranulocytosis**.

Psychopharmacology

Rapid MCQs

Choose the One Best answer:

1. Contraindication of lithium therapy includes each of the following EXCEPT:
A. renal impairment
B. liver disease
C. cardiac arrhythmia
D. pregnancy
E. severe vomiting &diarrhea

2. Which of the following is a characteristic feature of neuroleptic malignant syndrome:
A. hypothermia
B. agranulocytosis
C. increased liver enzymes
D. thrombocytosis
E. increased creatinine phosphokinase

3. Which of the following is a low potency first generation antipsychotics:
A. Clozapine
B. Haloperidol
C. Thioridazine (MCQ 2022)
D. Quetiapine
E. Risperidone

4. Select the best answer from the following:
A. chlorpromazine is more likely to cause EPS than haloperidol
B. haloperidol is less cardio toxic than chlorpromazine
C. haloperidol is a low potency antipsychotic
D. chlorpromazine is less likely to cause hypotension
E. haloperidol should not be given by intramuscular route

بسم الله الرحمن الرحيم

Psychotherapy

Psychotherapy: is the **use of psychological methods**, particularly when based on regular personal interaction, to **help a person change behavior, increase happiness, and overcome problems**, aims to improve an individual's well-being and mental health, to resolve or mitigate troublesome behaviors, beliefs, compulsions, thoughts, or emotions, and to improve relationships and social skills.

Some of the psychotherapy techniques:

1. **Interceptive exposure**: **Expose patients to feared body sensations**. Is the practice of strategically inducing the somatic symptoms associated with a threat appraisal and encouraging the patient to maintain contact with the feared sensations. It is an effective treatment technique for a range of anxiety conditions including **panic attacks and panic disorder**.
2. **Group therapy:** form of psychotherapy in which one or more therapists treat a **small group of clients together as a group**, refer to any form of psychotherapy when delivered in a group format.
3. **Cognitive behavior therapy (CBT):** a type of behavioral therapy, is a **talking therapy** that can help you manage your problems by changing the way you think and behave. It's **most commonly used to treat anxiety and depression.**
4. **Exposure and response prevention (ERP): one of the most effective forms of treatment for OCD**, behavioral therapy that **gradually exposes** people to situations designed to provoke a person's obsessions in a safe environment.
5. **Interpersonal therapy (IPT):** short-term form of psychotherapy, usually 12 to 16 sessions, that is used to **treat depression** and other conditions. As its name suggests, IPT **focuses on interpersonal relationships and social interactions** including how much support from others and the impact these relationships have on mental health.
6. **Family therapy:** a type of psychological **counseling** (psychotherapy) that can **help family members improve communication and resolve conflicts**. Usual goals of family therapy are improving the communication, solving family problems, understanding and handling special family situations, and creating a better functioning home environment.

بسم الله الرحمن الرحيم

Defense Mechanisms

Psychoanalysis and its related therapies are derived from **Sigmund Freud's psychoanalytic theories of the mind**.
Freud proposed that behaviors, or symptoms, result from unconscious mental processes, including defense mechanisms and conflicts between one's **ego, id, superego, and external reality**.

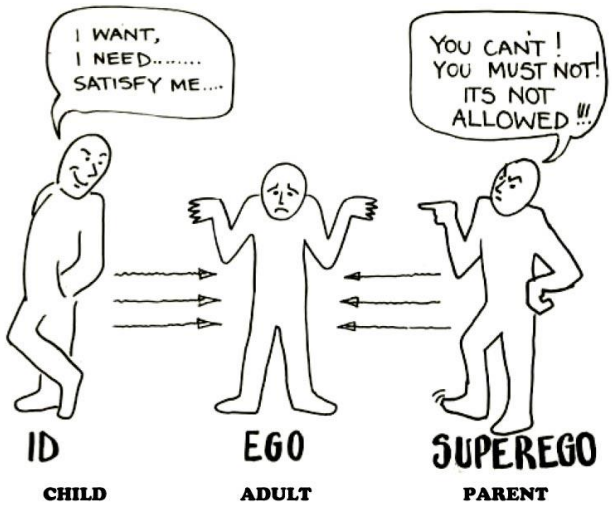
→ **Sigmund Freud is now known as the father of psychiatry.** (MCQ 2022)
he set the **Freud's Personality Theory** of ID, ego and superego

❑ Topographic theory:

1. **Unconscious**: Includes repressed thoughts that are out of one's awareness; involves primary process thinking. Thoughts and ideas may be repressed into the unconscious because they are embarrassing, shameful, or otherwise too painful.
2. **Preconscious**: Contains memories that are easy to bring into awareness, but not unless consciously retrieved.
3. **Conscious**: Involves current thoughts and secondary process thinking (logical, organized, mature, and can delay gratification).

❑ Structural theory:

1. **Id**:
Unconscious; involves instinctual sexual/aggressive urges and primary process thinking.
2. **Superego**:
Moral conscience and ego ideal "inner image of oneself that one wants to become".
3. **Ego**: Serves as a mediator between the id, superego, and external environment, and seeks to develop satisfying interpersonal relationships; uses **defense mechanisms** to protect oneself and relieve anxiety by keeping conflicts out of awareness, they are mostly unconscious processes. often classified into:
Mature, Neurotic and immature defenses.



Defense Mechanisms

Defenses	What is it?
Mature	
1. Altruism	Performing acts that benefit others in order to vicariously experience pleasure → (Cancer survivors help others with same disease)
2. Humor	Relief of anxiety with jokes → (Medical student jokes about board studying) 😜
3. Sublimation	Using negative emotion in a positive way → (Anxious person becomes a security guard)
4. Suppression	Ignoring an unacceptable impulse or emotion in order to diminish discomfort and accomplish a task. Is a Conscious defense mechanism.
Neurotic	
1. Controlling	Regulating situations & events of external environment to relieve anxiety
2. Displacement	Shifting emotions from an undesirable situation to one that is personally tolerable →(Student who is angry with his mother talks back to his teacher the next day and refuses to obey her instructions)
3. Intellectualization	Avoiding emotions through reasons → (Spouse going through divorce cites divorce statistic to friends to avoid admitting sadness)
4. Isolation of affect	Unconsciously limiting the experience of feelings or emotions associated with a stressful life event in order to avoid anxiety → (Woman describes the recent death of her beloved husband without emotion)
5. Rationalization	Explanations of an event to justify outcomes or behaviors and to make them acceptable → (My boss fired me today because she's not meeting her quotas, not because I haven't done a good job)
6. Reaction formation	Doing the opposite of an unacceptable impulse → (Man who is in love with his married coworker insults her)
7. Repression	Preventing a thought or feeling from entering consciousness. Is an unconscious defense mechanism
Immature	
1. Acting out	Avoiding emotion by bad behavior. Attention seeking, socially inappropriate behavior → (Child with sick parents misbehave at school)
2. Denial	Refusing to accept unpleasant reality → (Patients think doctor is wrong about diagnosis)
3. Regression	Performing behaviors from an earlier stage of development in order to avoid tension associated with current phase of development → (Stressed adult watches cartoon from childhood)
4. Projection	Attributing feelings/emotions to other → (A cheater accuses a classmate of cheating him off)
Others	
1. Splitting	Categorizing others at extremes → (Wonderful or horrible people)
2. Undoing	Attempting to reverse a situation by adopting a new behavior →(Patient think about hurting someone acts overly nice to person in response)

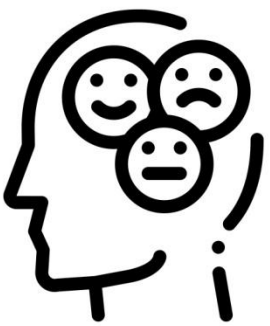
Chapter Three

Anxiety Disorders

Panic disorder
Social phobia
Specific phobia
Agoraphobia
Generalized Anxiety Disorder = GAD
Obsessive compulsive disorder = OCD
Acute stress syndrome = ASD
Post traumatic stress disorder = PTSD
Adjustment disorder

Mood Disorders

Major depressive disorders = MDD
Dysthemia
Cyclothymia
Mania
Hypomania
Bipolar 1 disorder
Bipolar 2 disorder



Psychotic Disorders

Schizophrenia = SCP
Schizoaffective disorder
Schizophreniform disorder
Brief psychotic event
Delusional disorders

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Anxiety, Mood & Psychotic Disorders

Disorder	Definition
Panic disorder	**Recurrent unexpected panic attacks** and at least 1month of **worrying** about implications of another attack or behavioral adjustment or avoidance.
Social phobia	Fear of social situations "socializing-speaking-gym…etc" with embarrassment.
Specific phobia	Fear of specific object/situation "animals, heights, flying, medical ttt"
GAD	**Excessive, irrational and exaggerated anxiety and worry about everyday life events** for no obvious reason. persisting at least six months.
OCD	Obsession: Recurrent and persistent thoughts, impulses or images that are **intrusive and unwanted** that cause marked anxiety or distress. Compulsion: Repetitive behaviors or mental acts that the person feels driven to perform **in response to an obsession aimed at reducing distress** or preventing some dreaded situation.
ASD	<1 month of severe symptoms of fear particularly **flashbacks and nightmares**, anxiety and avoidance following a threatening event.
PTSD	As ASD but > 1month
Adjustment d.	Maladaptive symptoms of depression, anxiety or behavioral changes. Develop within one month after stressful life event. Usually resolved within 6 months
MDD	At least 2 w. of severe persistent feeling of **sad and loss of interest**, cause distress or impairment in social or occupational functioning.
Dysthemia	Persistent depressive disorders, Low grade form of depression, **Less severe but more chronic**, Depressed mood most of time, **Last at least two years**
Cyclothymia	Fluctuating low-level depressive symptoms along with periods of mild mania (hypomania).
Mania	Abnormal persistent **elevated, expansive or irritable mood** lasting at least one week.
Hypomania	**Lesser degree of mania**, not accompanied by delusions or hallucinations, with good function, no need to hospitalization.
Bipolar 1 d.	Manic episode+/- depression +/- hypomania
Bipolar 2 d.	Hypomania and depression
SCP	Group of psychotic disorder characterized by the splitting of normal link perception, mood , thinking and contact with reality.between
Schizoaffective d.	Delusions or hallucinations for 2 weeks in the absence of mood disorder symptoms
Schizophreniform d.	SCP but for 1-6 month
Brief psychotic event	**Sudden onset** of psychotic symptoms, **Full remission within one month** Commonly follow stressful life events: death in the family and loss of the job
Delusional d.	One or more delusional, Last one month or longer, No abnormal behavior

Disorder	Duration	NO.	Presentation
Panic disorder	1 m.	>4	Psychologic → **fear of death, fear loss of control**, paranoia, derealization, depersonalization. Physiologic → tachycardia, palpitation, SOB, dyspnea, nausea, diaphoresis, trembling/tangling/numbness, chills, choking, dizzy …etc
Agoraphobia	> 6 m	>2	**Fear of** : public transportation, open spaces, closed spaces, crowd and being outside of the home alone. Example: fear of empty bus. Often co occur with panic disorder
GAD	> 6 m	>3	Restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbances.
OCD			Most common obsessions include: **Contamination**, Doubt/safety, Sexual and aggressive impulses, Symmetry and exactness , Somatic and religious preoccupations Most common compulsions include: Checking, Washing, Repeating, Ordering, **Counting** and Hoarding. Cycle: Obsession →Anxiety →Compulsion → Relief → Obsession ↷
ASD	< 1m.		**TRAUMA** = **T**raumatic event, **R**e-experience, **A**voidance, **U**nable to function, **M**onth , **A**rousal increase. Note : Recurrent instructive memories Recurrent distressing dreams
PTSD	> 1m.		**TRAUMA** but for more than month. **Follow traumatic event**: rape, war, physical assault
Adjustment disorder	< 6m.		Distress in excess of expected, Impairment of daily function Usually resolved within 6 months
MDD (MCQ)	> 2w.	5	Symptoms of depression, Depressed mood + **SIG E CAPS** **S**leep disturbances, Loss of **I**nterest in activities (anhedonia), **G**uilty feeling, **E**nergy loss and fatigue, **C**oncentration problem and inability to make decision, **A**ppetite and weight changes, **P**sychomotor agitation and retardation, **S**uicidal ideation or attempts
Dysthymia	**> 2y.**		Hopelessness, Sleep disturbance, Low appetite, Low energy, Low concertation and Low self esteem
Cyclothymic	**> 2y.**		**Mild mania and mild depression** Symptoms comes and go = mood swings + stable mood between periods
Mania (MCQ)	> 1w.	>3	**DIG FAST:** **D**istractibility, **I**rresponsibility, **G**randiosity, **F**lights of ideas, **A**gitation, **S**leep less, **T**alk too much, + pressure speech
Hypomania	4-7 d.		**little/no** impairment in functioning More energy but lead to productive activity, No psychotic symptoms
SCP	> 6m.	>2	**Positive symptoms** → delusions, **auditory hallucinations**, disorganized or catatonic behavior, disorganized speech. **Negative symptoms** → Avolition, Anhedonia, Asocialy and Alogia.
Schizoaffective	2 w.		Symptoms of Mood disorders and SCP.
Brief psychotic event	<1m.	>1	**Sudden** onset of psychotic symptoms, Full remission within one month.
Delusional d.	> 1m.		Example: Frequently check someone behind him. **Note: No hallucination**

Note 1: "**>**" in 2nd and 3rd column refer to "at least".
Note 2: "**NO.**" in 3rd column refer to number of clinical features needed to criteria.
Note 3: "**w.**" refer to "week" / "**m.**" refer to "month"/ "**y.**" refer to "year".

Disorder	Management
Panic disorder	**- 1st line: SSRI** or **SNRI, 2nd line: Benzodiazepine** clinically, a small dose of long acting benzodiazepine is started along with SSRI/SNRI to provide more immediate relief from distressing symptom. - Psychological ttt →**CBT,** interceptive exposure, Exposure to avoided situations is important
Social phobia	**Short term** : B blocker "propranolol" **Long term** : SSRI & group therapy
Specific phobia	Exposure therapy "**Systemic desensitization**", CBT, may benzodiazepines in some cases
GAD	**1st line**: SSRI or SNRI, **2nd line**: Benzodiazepine, **3rd line:** Adjunctive olanzapine, risperidone ,Mirtazapine **And** → CBT
OCD	**1st line**: SSRI, **2nd line**: Clomipramine And →Exposure with Response Prevention (ERP) And →combination of CBT + ERP
ASD	SSRI & group therapy. Benzodiazepines for acute symptoms
PTSD	SSRIs, SNRIs, Prazosin "alpha one blocker" and CBT. Avoid Benzo due to risk of addiction.
Adjustment d.	SSRI & psychotherapy
MDD	**Light to moderate** → Psychotherapy, medication **Moderate to severe** →Medication ± psychotherapy, ECT "see page 68" **Depression with psychotic features** → antidepressant + antipsychotic, gold standard is ECT **Medications**: **SSRI** →sertraline, fluoxetine. **TACS** →amitriptyline. **SNRI** →venlafaxine. Mirtazapine **Psychotherapy**: CBT, Interpersonal therapy (grief, transitions, interpersonal conflicts or deficits)
Dysthemia	Psychotherapy ± Antidepressants
Cyclothymia	CBT, group therapy and Mood stabilizers
Mania	1- **Lithium is drug of choice**. May "sodium valproate in Sudan" 2- IM **Haloperidol : drug of choice clinically** 3- Benzodiazepines help in rapidly control →restlessness, agitation, or insomnia 4- with antipsychotics start mood stabilizers "Lithium, S. valproate, Carbamazepine" in the same time and maximize use of it. 5- Switch from Haloperidol to Oral **Olanzapine** 6- **ECT** 7- Social ttt
Bipolar 1 d.	Always → **Lithium**, quetiapine. Acute manic episode → **divalproex, olanzapine, risperidone** Acute major depressive episode→ **Lamotrigine.** **Note: any drug can use for maintenance ttt**
SCP	Antipsychotics: → **typical as Haloperidol & atypical as olanzapine** CBT, Family therapy and social rehabilitation.
Schizoaffective d.	Mood stabilizers and Antipsychotics
Schizophreniform d.	Antipsychotics.
Brief psychotic event	Antipsychotics and may Benzodiazepines. Note: Full remission within one month.
Delusional d.	Antipsychotic drugs, antidepressants ,mood-stabilizers and CBT

Disorder	Etiology or Risk factors
Panic disorder	**Risk factors**: Genetic, History of physical abuse and Life stress.
Agoraphobia	Often occur with panic disorder.
OCD	Occur with Schizophrenia, Bipolar disorder, Eating disorders and Tourette syndrome "a neurological disorder characterized by sudden, repetitive, rapid, and unwanted movements or vocal sounds called tics".
ASD	Exposure to threatened death, injury, sexual insult.
PTSD	Follow traumatic event: rape, war, physical assault.
Adjustment d.	Within one month after stressful life event.
MDD	• Genetics "65-75% monozygotic twins" • Neurotransmitter dysfunction, • Psychosocial "Low self-esteem, Negative thinking" • Environmental "acute stressor" • Co-morbid psychiatric disorders "substance use"
SCP	**Risk factors**: • Urbans areas • Obstertic complications "hemorrhage, preterm labour, blood group mismatch, fetal hypoxia, maternal infection" • Cannabis use ➢ **Positive symptoms** due to increased dopamine in the mesolimbic system. ➢ **Negative symptoms** due to decreased dopamine in the mesocortical system.
Brief psychotic event	Commonly follow stressful life events: death in the family and loss of the job.

HIGHLIGHT "2" → Depression

- **Risk factors for depression:** Female, 20-50 years old, positive family history, childhood experiences "as loss of parent before age 11 ", personality structure, recent stressors , postpartum and lack of support network.
- **Subtypes of depression :** Atypical (most common), seasonal "in fall and winter; ttt→phototherapy", melancholic, catatonic, psychotic, mixed features and anxious.

HIGHLIGHT "3" → Typical Acute Greif

- **Involved in Mood abnormalities, it is normal response to loss of loved one**
- **"Kulber Ross model" →Typical acute Greif has five stages :** Stage 1"Denial", Stage 2 "Anger", Stage 3 "Bargaining", Stage 4 " depression" and Stage 5 "acceptance".
- Resolve within 6 months; but if last longer considered as **Complex Grief** and can lead to MDD.

HIGHLIGHT "4" → Schizophrenia

- **First rank symptoms of SCP according to Kurt Schneider are "7"**:

1. Thought insertion **2.** Thought broadcasting **3.** Thought withdrawal **4.** Thought echo
5. Passivity phenomena: somatic passivity, passivity of affect, passivity of volition
6. Auditory hallucinations: third person, running commentary, echo de la pensée **7.**Delusional perception.

- **Subgroups of schizophrenia: Paranoid** "persecutory, grandiose features or frequent auditory hallucinations", **Hebephrenic**" irresponsible/unpredictable", **Catatonic**, **Disorganized** "odd, bizarre behavior such as smiling, laughing, or talking to oneself" and **Simple** "insidious decline in function".
- **Imaging:**
  - **MRI/CT scan**: lateral ventricular enlargement
  - **PET scan** "positron emission tomography": Hypoactivity of frontal lobe & Hyperactivity of basal ganglia
- Monozygotic twin of a schizophrenia patient have 47% risk of be schizophrenic.
- Child of two parents with schizophrenia have 40% risk of be schizophrenic.
- **Common age is "18 to 25 years in men" and "25 to 35 years in women"**
- Mirror gazing &giggling are found in disorganized schizophrenia.
- Social withdrawal is found in simple schizophrenia.
- **Good prognosis** include: Old age of onset, female, married, no family history, high IQ, precipitants, positive symptoms, treatment compliance, acute onset and presence of mood components. So; **Poor prognosis** include the opposite of each factor of good prognosis.

HIGHLIGHT "5" → Drug Induced Psychotic Features

- **Drugs**: Anesthetics, antimicrobials, corticosteroids, antiparkinsonian agents, anticonvulsants, antihistamines, anticholinergics, antihypertensive, NSAIDs, digitalis, methylphenidate, and chemotherapeutic agents
- **Substances**: alcohol, cocaine, cannabis, benzodiazepines and barbiturates

Anxiety, Mood & Psychotic Disorders

Rapid MCQs

Choose the One Best answer:

1. Systemic desensitization is effective for the treatment of:
A. adjustment disorder
B. specific phobia
C. generalized anxiety disorder
D. agoraphobia
E. panic disorder

2. Recurrent intrusive thoughts that lead to resistance and worry occur in:
A. obsessive compulsive disorder
B. delusion
C. agoraphobia
D. panic disorder
E. generalized anxiety disorder

3. Mania tends to be characterized by all of the following EXCEPT:
A. increased sociability
B. irritability
C. decreased libido
D. over spending
E. goal-directed hyperactivity

4. For a diagnosis of bipolar 1 disorder, which one of the following criteria is a must:
A. At least one hypomanic episode
B. At least one MDD episode
C. Depressed mood for more than 2 years
D. Numerous periods of hypomania
E. At least one manic episode

Chapter Four

Miscellaneous Disorders

Eating Disorders
Personality Disorders
Sleep Disorders
Substance Use Disorders
Child Psychiatry: Autistic Disorder, ADHD & Enuresis
Somatic disorders
Suicide

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Eating Disorders

Eating Disorders are Mental disorder defined by **abnormal eating behaviors** that negatively affect a person's physical or mental health, more common in **woman**.

Q1. What are an examples of eating disorders?

Examples → Binge eating disorder, **anorexia nervosa**, **bulimia nervosa**, pica, rumination disorder, avoidant/restrictive food intake disorder and night eating syndrome.

Note: Coexist with →Depression, Anxiety, OCD, PTSD and Substance abuse.

Q2. What is the difference between Anorexia nervosa & Bulimia nervosa?

	Anorexia Nervosa	Bulimia Nervosa
Weight	Significantly underweight	Normal or overweight
Eating habit	Eat little food, few calories	Eat large amount of food, then **purges by vomiting** and may using laxatives
Presentation	**- BMI < 18 Kg/m2 (characteristic)** - Intense fear of gaining weight - Bradycardia - Hypotension - Decrease bowel sound - Xerosis = dry scaly skin - Hair loss: soft fine hair - Hyponatremia - Low creatinine - Hypokalemia - Decrease bone density → osteoporosis and osteopenia - pancytopenia	**1.Russel sign**: classic sign for bulimia nervosa which is scar or krunckles from induced vomiting. 2. Presented by **purging complications** : - Increase bicarbonate - Vomiting - Hypokalemia - Hypochloremia - Metabolic alkalosis - Parotid swelling - Erosion of dental enamel
Treatment	1) Nutritional rehabilitation, 2) Psychotherapy and 3) Olanzapine Hospitalization indicated in very low BMI, hemodynamically unstable, volume depletion or refuse to eat.	1) Nutritional rehabilitation 2) Psychotherapy 3) SSRIs

➢ **Note: Subtypes of Anorexia**:

1. **Restricting** →low calorie intake and exercise.
2. **Binge-purging**→ involves eating much larger amounts than normal (bingeing), then attempting to compensate by removing the food consumed from the body (purging).

Q3. What is Binge eating disorder and how to treat it?

Compulsive overeating excessively large amount of food, occurs at least once a week for three months, treated by **CBT as first line** & SSRI.

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Personality Disorders

Personality disorders	Presentation
Cluster "A"	**→ Weird : Odd and eccentric behavior**
1. Paranoid	**Distrust of others** even friend and family, Guarded, Suspicious, Struggles to build close relationship. Note: **ego** defense mechanism
2. Schizoid	**More comfortable alone**, Choose social isolation, Doesn't enjoy close relationship, Little or no interest in sexual experiences, Few or no pleasure activity and Lacks close friends.
3. Schizotypal	**Paranoia, Social anxiety**, Fear of social interaction, Few closed friends, Odd beliefs or magical thinking, Superstitious, Believes in **telepathy**.
Cluster "B"	**→ Wild : Dramatic and erratic behavior**
1. Antisocial	More common in **Men at least age of 18 year**, Disregard for rights of others, **break the law**, Impulsive and lack of remorse.
2. Borderline	More common in **Women**, Unstable person relationships, "**All people are very good or very bad**", Fear of abandonment, Display impulsivity, Self mutilation and Suicide gestures or attempt. Note: Splitting defense mechanism
3. Histrionic	Want to be the **center of attention**: talks loudly, tells wild story, use hand gesture, Inappropriate sexually provocative behavior and very concern with physical appearance.
4. Narcissistic	**Inflated sense of self** "think everything they do is great" , **Lacks empathy for others** "other people are competitor" , Wants to hear they are great and Overact to criticism with anger/rage.
Cluster "C"	**→ Wacky : Anxious and fearful behavior**
1. Avoidance	Social inhibition**, Feels inadequate**, Afraid of people wont like them, Afraid of embarrassment and Struggles with intimate relationships.
2. Obsessive compulsive	Preoccupied with order and control, **Loves to do list, Always need a plan**, Inflexible at work or in a relationship. Note: Behaviors help to achieve goals (contrast with OCD)
3. dependent	**Clingy**, **Low self confidence**, Struggles to care for them self, **Depend on other excessively**, **Rarely alone** and always in relationship, **Hard to make decision on their own**, Want someone to tell them what to do, Difficulty in expression and opinion and May involve in abusive relationship.

Notes:

1. If child < 18 year have presentation of antisocial personality disorder we called it **conduct disorder**.
2. Avoidant disorder patient want to socialized but cannot, which differ from Schizoid patient who prefer to be alone.

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Sleep Disorders

What is sleep?

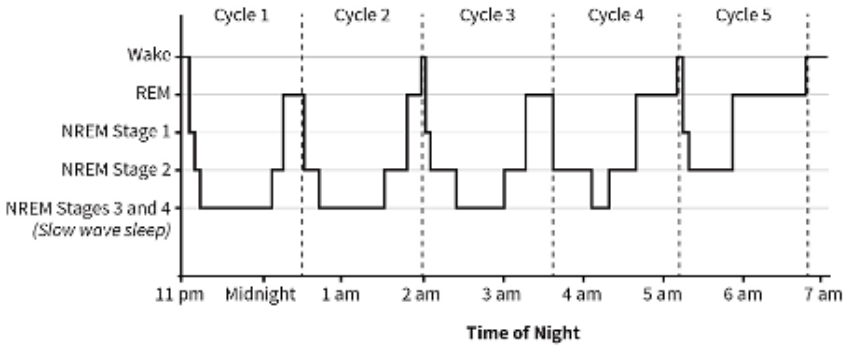
naturally recurring state of mind and body, characterized by **altered consciousness**, relatively **inhibited sensory activity**, **reduced muscle activity** and **inhibition of nearly all voluntary muscles during rapid eye movement stage** and **reduced interactions with surroundings**.

❑ Stages of sleep:

1. Non-rapid eye movement (NREM) sleep →transition from the waking sleep to deep sleep.
Stages of NREM: Awake, Drowsy, Stage I theta waves, Stage II (k complex-sleep spindles), Stage III delta waves, Stage IV 50% delta waves.

2. Rapid eye movement (REM) sleep →characterized by small, variable-speed brain waves, rapid eye movements, dreaming, increased heart rate, and muscle paralysis.

Note →About every 90 minutes, NREM sleep alternates with REM sleep.



❑ ECG patterns of different stages of sleep:

Type of sleep	Characteristics of stage	Description of wave pattern
Awake	The state of being awake and alert with awareness.	Low-voltage high-frequency beta waves (>14 Hz)
Drowsy	Reduced alertness and activity	Alpha waves prominent (8-13 Hz)
Stage 1	Transitional sleep	Theta rhythms (4-7Hz)
Stage 2	Slightly deeper sleep	Spindles (initiated from the thalamus) and K complex and mixed EEG activity
Stage 3 and 4 (slow-wave/deep sleep)	Rapid eye movements classically absent with stage 4 (the deepest sleep stage) lasting 20-40 minutes	Delta waves (<4 Hz)
REM	REM sleep featuring rapid eye movements.	Sawtooth waves – low voltage high frequency

Sleep disorders classified as either:

1. Dyssomnias: Insufficient, excessive, or altered timing of sleep.
2. Parasomnias: Unusual sleep-related behaviors.

Dyssomnias	Etiology	Characteristics	treatment
Insomnia	1. Idiopathic 2. Mood/anxiety disorders 3. Preoccupation with a perceived inability to sleep 4. poor sleep hygiene	- **Difficulty initiating** sleep → initial insomnia - Frequent **nocturnal awakenings** →middle insomnia - **Early morning awakenings** →late insomnia - **Waking up feeling fatigued & unrefreshed**	- **CBT** - **Chronotherapy**: (bright light therapy) entraining the circadian rhythm - **Benzodiazepines** - **Antidepressants** - **others**: melatonin, zolpidem, eszopiclone Zaleplon, Suvorexant
Hypersomnia	1. Viral infections : HIV pneumonia, infectious mononucleosis, Guillain–Barré 2. Head trauma. 3. Genetic: autosomal dominant mode	**Excessive sleepiness despite at least 7 hours of sleep**, with symptoms of **excessive quantity** of sleep, **reduced quality** of wakefulness, and sleep. Occurs at least three times per week for at least 3 months	- 1st line: **modafinil** or stimulants as **methylphenidate**; - 2nd line: amphetamine-like antidepressants as **atomoxetine**. **- Pitolisant** and **sodium oxalate** **- Scheduled napping**.
Obstructive sleep apnea	**Risk Factors** 1. Obesity 2. Increased neck circumference 3. Airway narrowing	Repetitive upper airway collapse during sleep → multiple **episodes of apnea or hypopnea per hour of sleep.** Excessive daytime sleepiness, Snoring, Frequent awakenings due to gasping or choking, Sleep fragmentation. Nonrefreshing sleep or fatigue, Morning headaches and HTN	**- Positive airway pressure**: continuous (CPAP) and in some cases bilevel (BiPAP) **- Behavioral strategies:** such as weight loss and exercise. **- Surgery:** tonsillectomy and selective upper airway stimulation implants
Central sleep apnea	1. idiopathic 2. Opioid use 3. Cheyne-Stokes breathing 4. High-altitude periodic breathing	- Cessation of air flow secondary to lack of respiratory effort - Abrupt awakenings accompanied by shortness of breath	- Treat the **cause**. - **CPAP/BiPAP**. - Supplemental **O2** - **Drugs**: acetazolamide, theophylline, sedative-hypnotics
Narcolepsy	**Pathophysiology:** 1. Linked to a loss of hypothalamic neurons that produce hypocretin. 2. May have autoimmune component	- by excessive daytime sleepiness and falling asleep at inappropriate times - At least three times per week for at least 3 months, with: **Cataplexy**, Reduced REM sleep latency, Sleep paralysisand **Hypnagogic & hypnopompic hallucination**	- **Sleep hygiene** - **scheduled daytime naps**. - Avoid shift work. - **Amphetamines** Others: methylphenidate, modafinil, sodium oxybate, and pitolisant - Cataplexy→ **Sodium oxybate** (drug of choice) Tricyclic antidepressants SSRIs and SNRIs

Sleep disorders classified as either:

1. **Dyssomnias**: Insufficient, excessive, or altered timing of sleep.
2. **Parasomnias**: Unusual sleep-related behaviors.

Parasomnias	Occur in	Characteristics	treatment
Nightmare disorder	REM	- Recurrent **frightening dreams** that occur during the second half of the sleep episode. - **Terminate in awakening with vivid recall** - No confusion or disorientation upon awakening. - Causes clinically significant distress or impairment in functioning	- Not always needed. - Desensitization or Imagery rehearsal therapy **(IRT)** → modify the outcome of a recurrent nightmare - drugs(rarely): **Prazosin** and **antidepressants** if related to PTSD
Sleep terror disorder	NREM	- Sudden **awakening with intense anxiety,** common in children "boys" - Patient does **not remember events** - episodes of sudden terror arousals associated with: **tachycardia, tachypnea, diaphoresis, and mydriasis**	- benign and **self-limited** **- Low dose of benzodiazepine** **- Supportive psycho ttt**
Sleep Walk Disorder 	NREM 3&4	- sitting up in bed, walking around, eating, and in some cases escaping outdoors. - Eyes are usually open with a blank stare and "glassy look." - Difficulty arousing the sleepwalker during an episode. - Dreams aren't remembered and there is amnesia for the episode.	- do **not need** to be treated. - education, **reassurance**, ensuring a **safe environment**, and **proper sleep hygiene**. - **low-dose of benzodiazepine**

Note: When taking a **sleep history**, ask about:

1. Activities prior to bedtime that may interfere with restful sleep.
2. Bed partner history.
3. Consequence on waking function; quality of life.
3. Drug regimen, medications.
4. Exacerbating or relieving factors.
5. Frequency and duration.
6. Genetic factors or family history.
7. Habits "alcohol consumption, use of caffeine, nicotine, illicit substances, and hypnotics".

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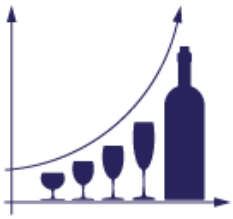
Substance Use Disorders



NOTE → See **Alcohol use disorder** in page 57 & 58

1. Cocaine

Blocks the reuptake of **dopamine**, **epinephrine**, and **norepinephrine** from the synaptic cleft, causing a **stimulant effect**. Is also local anesthesia (Na channel blocker). Cocaine activate sympathetic nervous system.

❖ Cocaine intoxication:

❑ Effects:

- **General effects:** **Euphoria**, Heightened self-esteem, Increase or decrease in blood pressure, Tachycardia or bradycardia, Nausea, dilated pupils, weight loss, Psychomotor agitation or depression, chills, and sweating.
- **Dangerous effects:**
  Seizures, Cardiac arrhythmias, Hyperthermia, Paranoia and Tactile Hallucinations.
- **Deadly effects:**
  Cocaine's **vasoconstrictive effect** may result in myocardial infarction, intracranial hemorrhage or stroke.

❑ Signs: → **Dilated pupils, Tachycardia and Hypertension**

"due to sympathetic nervous system activation and stimulate alpha and beta"

❑ Management:

1. For <u>mild-to-moderate agitation and anxiety</u>:
   Reassurance of the patient and **benzodiazepines**.
2. For <u>severe agitation or psychosis</u>:
   - **Antipsychotics** as haloperidol.
   - **Symptomatic support**: control hypertension, arrhythmias.
   - Temperature: ice bath, cooling blanket, and other supportive measures.

❖ Cocaine withdrawal:

With **stopping after chronic heavy use**, usually not life threating. Presented with: Depression and Anhedonia, Anxiety, Craving and Increase sleep.

Substance Use Disorders

2. Amphetamine

Modified phenethylamines, Stimulant, has indirect sympathomimetic
Increase synaptic dopamine/NE levels.

❖ Amphetamine intoxication:

- **Similar to cocaine**
- **Effects**: fever, euphoria, sympathetic stimulation, tachycardia, hypertension pupillary dilation, rhabdomyolysis, seizures and ischemia.
- **Treatment: benzodiazepines**.

❖ Amphetamine withdrawal as cocaine.

Depression and Anhedonia, Anxiety, Craving and Increase sleep.

3. Opioids

Activates opioids receptors: Mu, kappa and delta

- **Types**: **Morphine, hydromorphone, meperidine, codeine, heroin (diamorphine)**
- **Highly addictive** and **Tolerance develops:**
  Less effects of drug overtime and higher doses required to achieve effects
- **Clinical uses:** Pain control, acute pulmonary edema (iv morphine), cough suppression (codeine), diarrhea (lipoamide), shivering (meperidine)
- **CNS effects of opioid:** Pain relive, euphoria, sedation, slurred speech, respiratory depression, cough suppression, miosis = small pupil.
- **Peripheral nervous system effects:**
  Nausea, vomiting, constipation, skin warmth and flushing.

❖ Opioids intoxication:

Most common cause of drug overdose death.

- **Effects**:

✓ Euphoria to depressed mental status.
✓ Decrease respiratory rate.
✓ Decrease bowel sounds.
✓ Miotic “constricted” pupil.
✓ Seizure: most common with tramadol and meperidine.

- **Treatment**:

Naloxone “Short acting opioid antagonist” note: may cause withdrawal if high dose!

Substance Use Disorders

❖ Opioids withdrawal:

Naturally start 6-12 hours after last dose.
OR may caused by opioid antagonists → **Naloxone**.

- **Presentation:**

Restlessness, yawing, rhinorrhea and lacrimation, piloerection, nausea, vomiting, diarrhea, and abdominal cramps.

- **Treatment:**

1. **Clonidine** "Central alpha agonist"
2. Opioid agonist as: **Methadone** or **Buprenorphine**

➢ **Note:** Buprenorphine →Sublingual tablets, Partial agonist = agonist and antagonist.

Notes:

- **Heroin is Drug of abuse** →injected into vein: if contaminated needle or drugs lead to: Bacteremia "tricuspid endocarditis", HIV, HBV or HCV.
- Meperidine don't affect CNS.
- **Abuse potential:**

➢ **Heroin** → very high potential and there is no medical indication for it.
➢ **Cocaine** → high abuse potential.
➢ **Benzodiazepines** → low abuse potential.
➢ **Codeine** → very low potential and used as cough suppressant.

4. Benzodiazepines

Increase GABA activity : **Diazepam, lorazepam, oxazepam.**

❖ **Overdose** lead to:

CNS depressant, altered mental illness, slurred speech and ataxia.
Overdose treated by **Flumazenil** "benzodiazepines antagonist".

❖ **Benzodiazepine withdrawal**

can be life threating, presented as**:** Tremor, anxiety, depressed mood, hypersensitivity to sensation (noise, touch), psychosis and seizures. Treated by benzodiazepine.☺

5. Barbiturates

Anti seizure drugs , GABA activators, CNS depressant as alcohol.
: **Phenobarbital**, **pentobarbital**

Note→ Now replaced by benzodiazepines.

❖ **Overdose** lead to: respiratory depression, there is no antidote.
❖ **withdrawal** lead to: Delirium, Hallucination, Seizures, CVS collapse.

Substance Use Disorders

6. Marijuana

Derived form **cannabis** and stimulate cannabinoid receptors in CNS.

- **Presentation:** Euphoria, anxiety, impaired coordination, conjunctival injection, dry mouth, increase appetite, tachycardia and may hallucination.

➢ **Synesthetic cannabinoid**

- **What is it?** Pharmacological forms of dronabinol, available with capsule form.
- **Uses**: Cannabis withdrawal, in chemotherapy induced nausea and vomiting & appetite stimulation as in HIV patient.

7. Ecstasy

Methylenedioxymethamphatamine "**MDMA**" ☺

Increase release of serotonin and inhibit serotonin reuptake

- **Presentation**: Euphoria, alertness, increase sexual desire and bruxism "grinding teeth"
- **Effects**: Tachycardia, hypertension, hyperthermia, hypernatremia, hepatotoxicity and serotonin syndrome.

❖ **Ecstasy withdrawal** lead to: Depression and anxiety, fatigue and lethargy, difficulty in concentration and loss of appetite.

8. Caffeine

Methylxanthine "Adenosine receptors antagonist"

Lead to release of dopamine and NE, Renal adenosine blockade → **diuresis**.

HIGHLIGHT "6"

- **CNS depressant** → Alcohol, Barbiturates and Benzodiazepines
- **CNS stimulant** → Cocaine and Amphetamine

- **Pupil dilation** → Cocaine and Amphetamine
- **Pupil constriction** → Cannabis and Opioid

- **Tolerance** → Amphetamines, Ecstasy, Heroin and benzodiazepines
- **Most common cause of drug overdose death is heroin**

Substance Use Disorders

Rapid MCQs

Choose the One Best answer:

1. Which of the following drugs is a CNS stimulant:
A. Alcohol
B. Cannabis
C. Heroin
D. Amphetamine
E. ketamine hydrochloride

2. Which of the following not seen in heroin withdrawal:
A. Rhinorrhea
B. Muscle cramps
C. Miosis
D. Diarrhea
E. Mydriasis

3. Which of the following substances causes a higher number of deaths:
A. Alcohol
B. Nicotine
C. Cocaine
D. Heroin
E. Marijuana

4. Wernicke's encephalopathy is best treated by: "see alcohol abuse"
A. IV glucose infusion
B. IV saline infusion
C. IV thiamine
D. IV diazepam
E. IV fluphenazine

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Child Psychiatry

NOTE → See **Attention-deficit/Hyperactivity Disorder (ADHD)** in page 55

1. Pervasive Developmental Disorders

A **group** of disorders in **understanding**, **expressing language** and the **production of speech**, affect multiple areas of development, are manifested early in life, and cause persistent **dysfunction. Include:**

1- **Autistic Disorder** (most common)
2- Rett's Disorder
3- Childhood Disintegrative Disorder
4- Asperger's Disorder
5- Pervasive Disorder not otherwise specified

❑ Autistic Disorder

❖ What is it ?

Qualitative deficits in reciprocal social interaction and communication skills and restricted patterns of behaviors.

→ **deficits in language development and difficulty using language to communicate**

Occurs in 0.05% of children, more common in **males**, **onset before age 3 years**

❖ Etiology:

1. **Genetic** factors: Higher concordance rate in monozygotic than dizygotic twins
2. **Biologic** factors: high rates of seizure disorder and mental retardation.
3. **Immunologic** factors: Incompatibility and prenatal and perinatal insults

❖ Course and prognosis:

- Generally a **lifelong** disorder with a guarded prognosis.
- Two thirds remain severely handicapped and dependent.
- Improved prognosis if child has:

  IQ >70 and Communication skills are seen by age 5 to 7 years

❖ Common behavior problems included in autistic disorder:

- Hyper kinesis, hypo kinesis, aggressive, head banging, biting, scratching, hair pulling, and resistance to routine.
- **Note**: Prodigious cognitive or visuomotor capabilities may occur in a small subgroup, "be special in a certain thing, such as memorizing".

Child Psychiatry

❖ Case of autistic patient:

Child don't demonstrate special attention to important people in their lives and have impaired eye contact and attachment behaviors to family members and notable deficits in interacting with peers.

Note: Activities and play are often rigid, repetitive, and monotonous.

❖ Treatment of autistic disorder:

- **Goals of treatment** →target core behaviors, improve social interactions and communication, broaden strategies to integrate into schools, develop meaningful peer relations and finally increase long-term skills in independent living.
- **There is no cure for autism**, but various treatments are used to help manage symptoms and improve basic social, communicative and cognitive skills:

1. Early intervention.
2. **Remediation** (most effective treatment method) : Structured classroom training in a combination with behavioral methods..
3. Behavioral therapy.
4. Psychoeducation.
5. **Low-dose atypical antipsychotic** medications as risperidone, aripiprazole
: may help reduce disruptive behavior, aggression, and irritability
6. Parents are often struggle and need support and counseling.

2. Enuresis

❖ Definition and Criteria:

Repeated voiding of urine into clothes or bed, whether the voiding is involuntary or intentional, must occur **twice weekly for at least 3 months** or cause clinically **significant distress or impairment socially or academically** child's chronological or developmental age must be at least 5 years.

❖ Prevalence: "

The prevalence of enuresis decreases with increasing age"
5-10 % in 5 year olds, 1.5-5 % in 9-10 year olds and 1% in 15 years and older.

❖ Treatment:

Often self-limited, and a child with enuresis may have a spontaneous remission.

1. Star chart.

2. Restricting fluids before bed and night lifting to toilet trains the child.

3. Alarm therapy "**mainstay of treatment for enuresis"** which is triggered by wet underwear.

4. Behavioral Therapy: Classic conditioning with the bell (or buzzer) and pad (alarm) apparatus, Bladder training—encouragement or reward for delaying micturition for increasing times during waking hours.

5. Drugs if above fails and social or school impairment occur: Small dose **Imipramine.**

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Somatic disorders

1. Somatization

Physical symptoms due to stress or emotions, there is no medical illness and not consciously created for gain "factitious".

❖ Risk factors:

1. Depression and anxiety.
2. Female gender.
3. Less education.
4. Low socioeconomic status.

❖ Symptoms:

1. **Pain** symptoms: headache, back pain, joint pain.
2. **GI** symptoms: nausea, vomiting, diarrhea, bloating, gas.
3. **Cardiopulmonary** symptoms: chest pain, palpitation, dizziness.
4. **CNS** symptoms: muscle weakness, fainting, blurred vision.

❖ Diagnosis:

- Somatic symptoms that cause distress.
- Persistent though about seriousness of symptoms.
- Anxiety about symptoms.
- Excessive time and energy devoted to symptoms.
- **Persistent more than 6 months.**

❖ Management:

- Avoid debating if symptoms are psychiatric or medical.
- Regular visits with same physician.
- Limits tests and referral.
- Reassure patient that serious diseases are ruled out.
- Set goals of functional improvement.
- Address psychiatric issue gently.
- Psychotherapy
- May need antidepressant

HIGHLIGHT "7"

- **Hypochondriasis** "illness anxiety disorder or somatic symptom disorder ": is an excessively morbid fear or belief that one has serious illness present for **at least six months** and cause functional impairment. "Preoccupation with having undiagnosed illness".
- Hypochondriasis is often **accompanied**: Bipolar disorder, clinical depression, OCD, phobias, and somatization disorder. as well as a generalized anxiety disorder diagnosis at some point in their life.
- **CBT is an effective treatment for hypochondriasis**, about two-thirds of patients respond to treatment. Associated disorders treated accordingly.

Somatic disorders

2. Conversion disorder

Functional neurological symptom disorder characterized by **sudden onset** of Voluntary motor or sensory neurological symptoms following stressor.

❖ Symptoms:

"**Loss of vision**, double vision, sensitivity to light", **Limb weakness or paralysis**, "Loss of voice, slurred or stuttered speech", Memory issues, thinking problems, Headaches, migraines, Loss of sense of smell Chronic pain, Loss of sense of touch, **Loss of hearing**, Numbness, tingling, Seizures, Tremors, spasms, Sleep problems, Overactive bladder and Hallucinations.

❖ Note:

- Associated with **La Bella indifference "**Patient shown lack of concern about symptoms".
- **Neurological examination is normal** and positive finding is incompatible with disease.
- Co-exist with histrionic and avoidance personality disorders, and is more common in **female**.
- Diagnosis is accordingly "CT or MRI, EEG & history and examination to rule out other illnesses".

❖ Management:

- **CBT** involves learning about the disorder, recognizing triggers and symptoms, and learning new ways to respond and control them.
- **Hypnosis!**
- **Stress management** training to make symptoms more manageable.
- **Physical therapy** for weak limbs, walking problems, other movement problems.
- **Occupational therapy.**
- **Speech therapy.**
- **Medications** to treat the medical conditions that may co-exist in.

3. Factitious disorder

A- Factitious disorder on self:

- Called Munchausen syndrome: **Falsified** medical or psychiatric disorder, done **consciously** out of desire for attention.
- Patient may **feign illness or may aggravate genuine illness.**
- Patient often willing to go for tests or surgery.
- Example: patient afraid of work or afraid to be alone.
- **Risk factors:** Female gender, Unmarried or Prior or current healthcare worker.

B- Factitious disorder on another:

Falsified medical symptoms by caregiver , Often parent of child or caretaker of elderly.

4. Malingering

Consciously falsified medical symptoms done **for secondary external gain.**
End when secondary gain is achieved.
Example: 60 years old homeless present to hospital complain of headache and feel. better when doctor tell he will admit him in hospital.

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Suicide

Suicide is fatal act that fulfill the persons wish to die

❖ Terms used to describe suicide:

- **Suicide attempt:** self injurious behavior with non fatal outcome accompanies by evidence that the person intend to die.
- **Aborted suicide attempt:** potentially self injurious behavior with evidence that the patient intend to die but stopped the attempt before physical damage occur.
- **Para suicidal patient:** who injury him self by self mutilation but usually do not wish to die.
- **Suicidal ideation:** thought of wanting to die it's varies with in serious ness depend on suicidal plan intent.
- **Suicidal intent:** subjective expectation and desire to end life.
- **Lethality of suicidal behavior:** objective danger to life associated with suicide method.

❖ Risk Factors: "important"

1. **Male.**
2. Method: males have high rate of suicidal using highly lethal method.
3. Age: 45 year for male 65 year female, after 75 year in both.
4. Older attempt suicide less but more successful!
5. Marital status: more common in window **divorce** or **single.**
6. Mental illness: positive psychiatric illness more risky.
7. **Substance use.**
8. Personality disorder: Borderline personality disorder higher rate of Para suicide and Antisocial disorder for homicide.
9. Lack of family support.
10. Un employee.
11. **Previous suicidal attempt.**
12. **Family history of suicidal attempt.**

❖ Management:

- **Admission**
- **24 close monitoring** → patient alone and remove the dangerous objects in room.
- **Assessment**: Whether attempt planned or impulsive, lethality of method, assess chance of discovery, reaction of being safe, guilt feeling, if he write note and coping of stress.
- **ECT**: Suicidal and Homicidal are indication for ECT.
- Use **medication according to diagnosis.**

Suicide

HIGHLIGHT "8"

SAD PERSONS scale for suicide

Score: 0-10

1. Sex (male)
2. Age (adult and elderly)
3. Depression
4. Prior attempts
5. Ethanol or drug
6. Rational thinking loss (psychosis)
7. Sickness (medical illness)
8. Organized plan
9. No spouse (lack of social support)
10. Stated intent to harm themselves

0-4 → low risk
5-6 → medium risk
7-10 → high risk

❑ **Note: Violence is Intentional act of doing bodily harm to another person.**

➢ **Include**:

1. Assault
2. Rape
3. Robbery
4. Homicide
5. Physically and sexually abuse.

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Important Notes you must know!

- **ADHD** is more common in **boys** than in girls.
- Rett's Disorder common in **girls** than in boys.
- Drug of choice in the **ADHD** is **methylphenidate**.
- **Depression associated with highest risk of suicide**.
- Epilepsy associated with 50% risk of major depression.
- **Characteristic feature of delirium is clouding of consciousness.**
- Confabulation is a characteristic feature of dementia and Alcoholic Korsakoff syndrome.
- The earliest sign of dementia is disturbance in memory.
- **CNS depressant** → Alcohol, Barbiturates and Benzodiazepines.
- **CNS stimulant** → Cocaine and Amphetamine.
- Cocaine and Amphetamine →**pupil dilation.**
- Cannabis and opioid cause → **pupil constriction.**
- **Most common cause of dementia is Alzheimer disease.**
- **Tolerance** can develop rapidly with: Amphetamines, Ecstasy, Heroin and benzodiazepines.
- **DSM** → Diagnostic and Statistical Manual of Mental Disorders.
- **ICD** → International classification of diseases.
- **Serial sevens test** is clinical test used to test mental function by counting down from one hundred by sevens.
- Personality disorder cannot be diagnosed before age 18.
- **Most common cause of drug overdose death is heroin**.
- Awaking much earlier than normal is **terminal insomnia**, and associated with severe depression.
- **The most characteristic feature of mania is hyperactivity**.
- **Most common obsessions is contamination**.
- **Scientists:**
  - **Sigmund Freud** set the Freud's Personality Theory of ID, ego and superego.
  - **Emil Kraepelin** distinguished the catatonic, hebephrenic and paranoid clinical varieties.
  - **Eugene Bleuler** coined the term schizophrenias. Also defined "4A"; **A**mbivalence, **A**utistic behavior, **A**bnormal associations and **A**bnormal (blunting of) affect.
  - **Kurt Schneider** set the First rank symptoms of schizophrenia.
- **Hypomanic episode is more energy than mania but lead to productive activity** "mania is unproductive"
- Treatment of choice of nocturnal enuresis is **alarm therapy.**
- **Most common obsessions is contamination.**
- **SIG E CAPS** presentation of MDD and **DIG FAST** of Mania are very important for MCQs.
- **La Bella indifference** seen in conversion disorder.
- Clinical Schizophrenia appear when biological factors interact with environmental factors.
- Symptoms of ADHD are often present by age 3 years. "see page 55"
- **Wernicke's encephalopathy** is an important long-term complications of alcohol intake, caused by thiamine (vitamin b1) deficiency. If not treated progress **to Korsakoff syndrome.** "see page 58"

Chapter Five

History taking & Examination

بسم الله الرحمن الرحيم

History taking & Examination

Before you start; you must go back to the Psychopathology chapter page 3 and presentation of Anxiety, Mood & Psychotic Disorders page 24

1. Personal (Identifying) Data:

Name, Sex, Marital Status, Age, Residence, Occupation, Educational Level, Patient brought by, Reasonable Referred
Informer: Is he or she reliable? Date of admission.

2. Presenting Complaint:

the main problems in the patient's own words,
in one or two sentences + duration.

3. History of Presenting Illness:

- The patient's **psychosocial and environmental conditions** "predisposing to, precipitating, perpetuating, and protecting against the current episode".
- The **patient's support system** "whom the patient lives with, distance and level of contact with friends and relatives".
- **Neurovegetative symptoms** (quality of sleep, appetite, energy, psychomotor retardation/activation, concentration).
- **Suicidal ideation/homicidal ideation**.
- **How work and relationship have been affected**

(for most diagnoses in the **DSM-5** there is a criterion that specifies that symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning).

- **Psychotic symptoms** (e.g., auditory and visual hallucinations, delusions).
- Establish a **baseline of mental health**.
- Patient's **level of functioning when well.**
- **Goals** "outpatient setting".

Examples of questions can help you:

Sleep: lack of sleep? disturbance of sleep? increase sleep? times of wakeup and sleep?
Appetite: poor appetite? increase appetite? normal appetite?
Weight: loss of weight? gain of weight?
Mood: What are you feeling? Happiness? Sadness? Normal?
Hygiene: washing? take care of himself? neglect himself?
Social withdrawal? Lack of concentration? Guilt feeling?
Activity: increase? Decrease? Lack of interest?
Hearing voices? Seeing images?

History taking & Examination

4. Past psychiatric History:

- history of suicide attempts.
- history of self-harm “cutting, burning oneself”.
- information about previous episodes.

Note: for episode ask about →

time, duration, complains, medication used, ECT intervention, functioning, compliance

- other psychiatric disorders in remission.
- medication trials.
- past psychiatric hospitalizations.
- current psychiatrist.

5. Past medical History:

- Ask specifically about head trauma, seizures and convulsion.
- if women pregnancy status.
- Serious medical illness.
- Loss of consciousness.

6. Family History:

- Mother, Father, Sibling and number ordering of patient.
- Relationship.
- Financial support.
- Family history of psychiatric illness “include substance use, suicides.

and response to specific psychotropic agents as patient may respond similarly”

7. Personal History:

Is important as it helps you to understand what has led to your patient becoming the person they are.

Ask about:

family of origin, early experiences, schooling, friendships, qualifications, further or higher education.

You can then move on to ask about the following areas:

- Employment history.
- Interests and current friendships.
- Significant relationships, marriage and children.
- Psychosexual history.
- Forensic History.
- Use of alcohol and illicit drugs.

History taking & Examination

8. Social History:

- **Sexual history**:
Men arch, Puberty, Fantasies and Experience "homosexual or heterosexual"
- **Marital History**; How long relationship? Kids? If divorced why?

9. Drug History:

Sensitivity, Side effects, Current medication and allergy.

10. Substance History:

Name? Route of admission? "IV, Oral or Inhaled" When? Whom?
Where? Effect? How many? Tried to stop? Withdrawal symptom? Craving?
Possible dependence?

11. Personal History:

indication of the patient's personality and character before the onset of mental illness. It can be difficult to ascertain retrospectively.
Indirect evidence of it can be provided from the personal history.

Ask about:

- Coping styles, interests, hobbies and activities and
how the person usually relates to other people?
- Patient is Sociable, Calm, Criminal or Obsessive?

Mental State Examination

1. General Appearance:

Weight, height, hygiene, disinhibition, over familiar, dress,
psychomotor "agitated, retarted, normal"
up normal movement "tremor , up normal gate, catatonic, sign of extra pyramidal symptom", **facial expression**, **eye to eye contact** "poor, avoid, maintain" and **rapport, consciousness, cooperation and hallucinatory attitude.**

2. Speech:

- **Rate** "pressured, slowed, regular"
- **dysprosody** "unusual speech rhythm, melody, intonation or pitch"
- **Articulation** "dysarthria, stuttering"
- **Accent/dialect**
- **Volume/modulation** "loudness or softness"
- **Tone**
- **Long or short latency of speech**
- **Coherent** or **incoherent**

3. Mood:

Mood is the emotion that the patient tells you he/she feels, often in quotations.
- **Elevated or depressed** mood.
- Other **mood states** such as anxiety and panic.
- Ask the patient to **describe their mood subjectively.**
- you also need to **assess their mood and affect objectively**.
- **Associated symptoms.**

4. Thinking :

Stream, Form, Content and Poisson.
Examples: Pressure of thought, flight of ideas, circumstantiality, thought blocking, dysphasia, thought withdrawal, thought insertion & delusions.
Note → see page 6 & 7

Mental State Examination

5. Perception:

- **Illusion**:

Inaccurate perception of existing sensory stimuli, "wall appears as if it's moving!"

- **Hallucination**:

- Describe the sensory modality: Auditory (most common), visual, olfactory, or tactile.
- Describe the details "auditory hallucinations may be ringing, humming, whispers, or voices speaking clear words".
- Ask if the hallucination is experienced only while falling asleep "hypnagogic hallucination" or upon awakening "hypnopompic Hallucination".

- Also **pseudo hallucination**, **derealization** or **depersonalization.**

6. Cognitive Function:

- **Consciousness**: alert, drowsy, lethargic, stuporous or comatose.
- **Orientation**: To person, place, and time.
- **Calculation**: Ability to add/subtract.
- **Memory**:

1. Immediate "registration" can be tested by asking a patient to repeat several digits or words.
2. Recent "short-term memory" events within the past few minutes, hours or days.
3. Remote memory "long-term memory".

- **Fund of knowledge**: Who is the president? Who was Maradona?
- **Attention/Concentration**: Ability to subtract serial 7s from 100 "Serial sevens test" or to spell "world" backward.
- **Reading/Writing**: Simple sentences "must make sure the patient is literate first".
- Abstract concepts: Ability to explain similarities between objects and understand the meaning of simple proverbs.

7. Insight:

Insight is not an 'all or nothing' attribute, often described as "good, partial or poor"

- Does the patient believe they are unwell in any way?
- Do they believe they are mentally unwell?
- Do they think they need treatment (pharmacological, psychological or both)?
- Do they think they need to be admitted to hospital?

8. Judgment!

Judgment is the patient's ability to understand the outcome of his or her actions and use this awareness in decision making; it is best determined from information from the HPI and recent behavior.

Chapter Six
Questions & Short test

Problems Questions
MCQs
OSPE Questions
Short test

بسم الله الرحمن الرحيم

Problems Questions

1. Previous exams questions:

1) A 29 year old man is brought to the hospital because he was found running around on the streets with no shoes on in the middle of winter, screaming to everyone that he was going to be elected president. He was found to be irritable and excited, he doesn't seen to be able to concentrate as well as he had previously. Six weeks prior to this he had been to the emergency room for an acute asthma attack.

1. What is the most likely diagnosis? **Mania**
2. Outline the management?
   Lithium, Haloperidol, IV Benzodiazepines, ECT and CBT

2) While driving his car recklessly, a university student had a fatal car accident causing severe head injury and subsequent death of his classmate in the passenger seat. Luckily, he was unhanned. However, few weeks later he started to experience dreams about the event, insomnia and increased arousal. Ultimately he started to drop class.

1. What is the most likely diagnosis? **PTSD**
2. Mention two clinical features of this disorder?
   Avoidance of reminders, Hypervigilance, social dysfunction …etc
3. Mention one differential diagnosis? **Adjustment disorder**
4. What groups of drug are used in treatment of this disorder?
   SSRI, SNRI, alpha1 blockers "Prazosin"

3) A 25 year old man with fear of having run over someone when he is driving, he has to stop his car and get out to make sure if there is a body in the road every time he drives. He also said that he checks his doors and windows many time to ensure they are locked. Also he spends much time in dressing. He tries to resist doing these things which he feels they don't make sense but feels anxious if he doesn't go and check.

1. What is the most likely diagnosis? **OCD**
2. Mention one effective non-pharmacological treatment?
   Behavioral therapy → ERP "Exposure with Response Prevention" & **CBT**

4) A 18 year old male patient was brought by his father to psychiatrist. His father stated that over the past 6 months his son started to behave abnormally with periods of excitement, self-talking and laughing followed by periods of immobility and described odd posturing for several hours. Psychotropic medications were used for 3 months without response.

1. What is the most likely diagnosis? **Schizophrenia**
2. What is the treatment of choice? **ECT,** others →CBT, Family therapy and social rehabilitation
3. Mention the main presentation found in your diagnosis?
   Auditory hallucinations

Problems Questions

5) A 30 years old woman has 2 years history of repeated episodes of hypomania and depression.

1. What is the most likely diagnosis? **Bipolar disorder**
2. Mention one important medication useful in controlling these episodes? **Lithium**
3. Mention two important tests before starting this drug?
   Thyroid function test, CBC and Creatinine
4. Mention one important test after starting this drug? **Serum lithium level**

6) A 5 years old child is brought to the psychiatrist because of difficulty in his ability to focus attention at school. He fidgets and is not able to stay seated in class. At home he talks excessively and cannot be put off for even a minute.

1. What is the most likely diagnosis? **ADHD**
2. What is first choice drug used in treatment? **CNS stimulants: methylphenidate**
2. Outline the management?

*** Pharmacologic treatment is considered the first line of treatment for ADHD:**

1. CNS stimulants: methylphenidate
2. Norepinephrine uptake inhibitor: Atomoxetine (Strattera)

*** Psychosocial Interventions:**

Psychoeducation, Academic organization skills remediation, Parent training, Behavior modification in the classroom and at home, CBT and Social skills training.

HIGHLIGHT "9"→ ADHD

- ADHD have significant **impairment in academic functioning** as well as in **social and interpersonal** situations.
- Frequently **associated with comorbid disorders** including learning disorders, anxiety disorders, mood disorders, and disruptive behavior disorders.
- ADHD is common in male than female.
- **Presentation of ADHD patient → Symptoms of ADHD are often present by age 3 years** and characterized by: **impulsiveness** and an inability to delay gratification, **hyperactivity**, **attention deficit** "short attention span, distractibility, perseveration, failure to finish tasks, inattention, poor concentration"
- ADHD affects up to **5-8 % of school-aged children**, with 60-85% of those diagnosed as children continuing to meet criteria for the disorder in adolescence, and up to **60% continuing to be symptomatic into adulthood**.
- Causes and Risk factors include: Genetic "75% heritability", Prenatal toxic exposures, Prematurity, Prenatal mechanical insult to the fetal nervous system, Food additives, colorings and sugar

Problems Questions

7) A 23 year old lady delivered her first child normally, but in the first week of her delivery she suddenly started to be agitated and restless, confused with labile mood and refused to breast feed her baby saying that it is not her baby it is the devil and she said she is hearing voices talking about her.

1. What is the most likely diagnosis? **Postpartum psychosis**
2. What other types of psychiatric disorders associated with delivery?
   Postpartum depression and postpartum blues

3 how you manage this case?
Separate baby, admission mother, give Antipsychotics, may need ECT and psychotherapy

8) A 27 year old woman has been feeling sad for the past 2 weeks. She has little energy & has trouble concentrating. She states that 6 weeks ago she had been feeling very good with lots of energy & no need for sleep. She said that this pattern has been occurring for at least the past 3 years; though the episodes have never been so severe that she couldn't work.

1. What is the most likely diagnosis? **Cyclothymia**
2. What is the best treatment of this patient? **Mood Stabilizer**

9) An 11 years boy frequently leaves his bed & goes to living room late at night. On several occasions his parents have talked to the child at that time & found him as if he were in a dream & staring into space with his eyes opened. The next day the child denies having left his room.

1. What disorder most likely is this child exhibiting? **Sleep walking**
2. What is the best treatment for this patient ?
   Reassurance and safety measures

10) A 23 years old woman visits a physician because of multiple physical complaints, then after a thorough examination, she found to have no physical problem, she presented her complaint in a dramatically & aggravated ways & her history reveals numerous medical visits to various physicians.

1. What is the most likely diagnosis? **Somatization disorder**
2. What are the principles of management of this patient?
   Regular visits with same physician, limits tests and referral, set goals of functional improvement and psychotherapy
3. If a medication was to be prescribed for this patient, what is the best option?
   Antidepressants

Problems Questions

2. Other important topics for problems questions:

1) Generalized anxiety disorder

- **What is GAD?** Excessive, irrational and exaggerated anxiety and worry about everyday life events for no obvious reason. persisting at least six months.
- **What is the presentation of GAD?**

Restlessness, fatigue, difficulty concentrating, irritability, muscle tension and sleep disturbances. More common in **women**. Last of **more than 6 months**

- **Outline the management of GAD?**

- 1st line **SSRI** or **SNRI**
- 2nd line **Benzodiazepines** only for short term use
- 3rd line Adjunctive **olanzapine** or **risperidone**
- **CBT** also 1st line, include → Psychoeducation, Cognitive interventions, Exposure, Relaxation strategies, Problem Solving, Assertiveness training and Relapse Prevention

2) Alcohol Intoxication

- **What is alcohol and what it's action??**

➢ Alcohol (ethyl alcohol/ethanol), found in alcoholic beverages, metabolized by liver, activates GABA, dopamine, and serotonin receptors in CNS, inhibits glutamate receptor activity and voltage-gated calcium channels.

✓ **NOTE**: GABA receptors are inhibitory, glutamate receptors are excitatory
So →**Alcohol is a potent CNS depressant**

- **What are alcohol biomarkers?**

AST, GGT, High MCV and Hypertension

- **What is alcohol intoxication?**

When **drinking too much alcohol in a short amount of time**, blood alcohol concentration (BAC) of greater than 25–80 mg/dL or 0.025–0.080%

- **What are the clinical features of alcohol intoxication?**

CNS depressant, slurred speech, incoordination, steady state, stupor, coma and respiratory depression. Death may occur. ☹

- **How to treat alcohol intoxication?**

○ **Monitor** → Airway, breathing, circulation, glucose, electrolytes, acid–base status.
○ Give parenteral **thiamine** (for Wernicke's encephalopathy) and **folate**.
○ Naloxone may be necessary to reverse effects of co-ingested opioid.
✓ Note: thiamine before glucose, as it's a necessary cofactor for glucose metabolism

- **What is ALCOHOL POISONING?**

Very high BAC "> 400mg/dl" which lead to respiratory depression.

Problems Questions

3) Alcohol Withdrawal

- **What is Alcohol withdrawal?**

Symptoms occur following a **reduction in alcohol use after a period of excessive use**. Cessation of use causes a compensatory hyperactivity with glutamate excitotoxicity.

- **What are the clinical features of alcohol withdrawal?**

Tremor, Anxiety, GI upset, Headache, Sweating, Palpitation

- **Outline the management of Alcohol withdrawal?**

- **Benzodiazepines** (lorazepam, diazepam, or chlordiazepoxide) given in sufficient doses to keep the patient calm and lightly sedated, then tapered down slowly.
- **Carbamazepine** or **valproic acid** can be used in mild withdrawal.
- **Banana bag**: Thiamine, folic acid, and a multivitamin treat nutritional deficiencies
- Electrolyte and fluid abnormalities must be corrected.
- **CIWA scale** → Monitor withdrawal signs and symptoms with the Clinical Institute Withdrawal Assessment scale.

- **What are severe symptoms of Alcohol withdrawal and when to occur?**

- **Generalized tonic clonic seizure** → Occur 24-48 hours after last drink
- **Visual hallucination** → Occur 24-48 hours after last drink : Seeing insect or animal, Hearing voice, Tactile sensation: feel a bug on the skin.
- **Delirium tremens** → Occur between 48-96 hours after last drink,

symptoms: delirium, visual hallucination, agitation, gross tremor, autonomic instability, and fluctuating levels of psychomotor activity.

Note: alcohol withdrawal has 20% mortality rate, **Death** occur from hyperthermia, arrhythmia, cardiac collapse and electrolytes imbalance, **treat with benzodiazepines**.

- **What is the most severe withdrawal manifestation? Delirium tremens**

HIGHLIGHT "10" → Alcohol Abuse Complications

❖ **Wernicke's encephalopathy** is an important long-term complications of alcohol intake, caused by thiamine (vitamin b1) deficiency. If not treated progress to **Korsakoff syndrome.**

- Features of Werincke's encephalopathy: Visual disturbance/nystagmus, Gait ataxia & Confusion.
- Features of Korsakoff syndrome: anterograde amnesia, apathy, compensatory confabulation.
- Both associated with: Thiamine B1 deficiency, alcohol use, atrophy of mammillary bodies and damage to thalamic nuclei.

➢ Note : Korsakoff syndrome is permanent and affect recent memory more than remote.

- Treatment for both: **Banana bag** contained: (Thiamine "VB1", Folate "VB9" and Magnesium), **Pyridoxine** "VB6", **Calcium** and **Phosphorus.**

4) Neuroleptic malignant syndrome

- **What is NMS?**

Rare dangerous reaction to high potency first generation drugs Usually 7-10 days after treatment started.

- **What is presentation of NMS?**

Fever and rigid muscles, Mental status changes "encephalopathy", Elevated creatinine kinase "muscle damage", Myoglobinuria due to acute renal failure "rhabdomyolysis".

- **How to treat NMS?**

Muscle relaxant and Dopamine agonist: bromocriptine.

Problems Questions

5) Postpartum Blues, Depression & Psychosis

- **What is postpartum psychosis?**

Severe mental illness characterized by extreme difficulty in responding emotionally to a newborn baby, it can even include thoughts of harming the child

- **What are the symptoms of postpartum psychosis?**

Delusions or strange beliefs, hallucinations, very irritated, hyperactivity, decreased need for or inability to sleep, paranoia and suspiciousness, rapid mood swings and difficulty communicating at times.

- **What is the difference between Postpartum psychosis, depression and blues?**

	Post Partum Blues	Post Partum Depression	Post Partum Psychosis
Onset	3-5 days after delivery	3-6 months	Almost Always within 8 weeks
Incidence	50 - 85%	10 - 15%	0.1 - 0.2%
Duration	1 day to 2 weeks	2 weeks to 12 months	Always within 8 weeks
Symptoms	Mild insomnia, tearfulness, fatigue, irritability, poor concentration	Irritability, **nihilistic delusions**, labile mood, anxiety, phobias, difficulty falling sleep with ideation of death and **suicidal and infanticide attempt**	Delusion, confusion, attention deficits, **Hallucination**, Affective mood and **Infanticide attempt**
Management	**- Self limited** - Supportive ttt - Psychotherapy - Observe → 20% will develop post partum depression in the 1st year	**- Emergency** - Admission - Separate baby - **Antidepressant** - ECT - Psychotherapy	**- Emergency** - Admission - Separate baby - **Antipsychotic** - ECT - Psychotherapy-

Problems Questions

6) Delirium

- **What is Delirium?**

State of mental confusion that starts suddenly and is caused by a physical condition of some sort. You don't know where you are, what time it is, or what's happening to you.
It is also called an 'acute confusional state

- **What are the types of Delirium?**

Mixed type (most common), Hypoactive (quiet) and Hyperactive (ICU psychosis)

- **What is the Etiology of Delirium according to DSM-5?**

Substance intoxication, Substance withdrawal, Medication, Medical condition and Multiple etiology

- **What are the Risk factors of Delirium?**

Age, preexisting cognitive impairment or depression , history of delirium, alcohol use or withdrawal, infection, pain, dehydration, malnutrition, sleep deprivation, organ failure and hearing/vision impairment.

- **What is the clinical manifestation of delirium?**

Disorder of attention and awareness (orientation), Cognitive deficits develop acutely over hours to days, Symptoms fluctuate throughout the course of a day , worsening at night, Deficits in recent memory, Language abnormalities, Perceptual disturbance, Circadian rhythm and emotional symptom.

- **Outline the management of delirium?**

1. Calm the patient and avoid use of restraints.
2. Treatment the cause.
3. **Haloperidol is the treatment of choice**.
4. D2 an antagonist can be given in case of agitation, but should be avoided in parkinsonism patients.
5. Use Benzodiazepine only if delirium cause by Alcohol or Benzodiazepine withdrawal.

What is the difference between Delirium & Dementia?

See the next page

	DELIRIUM	DEMENTIA
ONSET	Acute	Insidious (months to years); may be abrupt in stroke/trauma
VITAL SIGNS	Typically, abnormal (fever, tachycardia)	Normal
COURSE	Rapid, Fluctuating	Progressive
DURATION	Hours to weeks	Months to years
CONSCIOUSNESS	Altered	Usually clear
ATTENTION	Impaired	Normal except in severe dementia
ALERTNESS	Impaired	Normal
BEHAVIOR	Usually agitated, withdrawn, or depressed; or combination	Intact early
SPEECH	Incoherent; rapid/slowed	Problems in finding words
PSYCHOMOTOR CHANGES	Increased or decreased	Often normal
REVERSIBILITY	Usually	Irreversible

HIGHLIGHT "11" → Dementia

❖ Dementia is a chronic progressive state of global cortical dysfunction

❖ characterized by:

1. Mood and Memory disturbance
2. Behavioral changes
3. Multiple cognitive defect

➢ **But without consciousness disturbance**

❖ **Pathogenesis:** Brain neuronal loss due to normal degeneration or cell death secondary due to organic disease of the brain.

❖ **Cause: Alzheimer's disease "most common cause and very important"**

➢ Other causes: Cerebrovascular as stroke "second most common cause", Parkinson's disease, Wilson's disease, multiple sclerosis ,Huntington's disease, head trauma, alcohol, toxin, AIDS and metabolic endocrine &nutritional disorders.

❖ **Features**:

➢ Global disturbance of cognitive functions:

- Disturbed attention, perception and orientation
- Memory loss

Other:

1. Emotional disturbance.
2. Psychosis symptoms.
3. CNS manifestation.
4. Disturbance of executive function.
5. Impairment of judgment

❖ **Management**:

- Treatment of the cause in reversible types as Vitamins deficiency.
- No specific treatment for Irreversible types: **Anticholinesterase inhibitors**
  "may help delay memory and cognitive decline"
- **Supportive measurement:**

✓ Physical and psychological rehabilitation.
✓ Emotional support for the patient and his family.
✓ Safe, calm and orienting environment.
✓ Diet
✓ Maintain physical health and treat the medical illnesses.

- **Symptomatic treatment** for anxiety or psychotic symptoms "Haloperidol, Risperidone or benzodiazepines"

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MCQs

Previous exams questions

1) The treatment of choice in neuroleptic malignant syndrome is:
A- Haloperidol
B- Promethazine
C- Bromocriptine
D- Flupenthixol
E- Lorazepam

2) Functional inability of speech:
A- Alogia
B- Stuttering
C- Mutism
D- Aphonia
E- Stammering

3) Regarding to Postpartum psychosis, what is true:
A- occurs most commonly in multigravida women
B- is rarely correlated with perinatal complications
C- usually occurs abruptly, with no prodromal psychotic symptoms
D- is essentially an episode of a psychotic disorder
E- almost always begin within 8 weeks of delivery

4) A 32 years old lady presents with refusal to eat, hopelessness, guilt feelings and severe sadness for the past 4 weeks. During this period she had difficulty to sleep, and fatigability in addition to loss of desire in previously enjoyable activates she has death wishes. What is the most appropriate treatment at this point:
A- tricyclic antidepressants
B- SSRI
C- mono amine oxidase inhibitors
D- electroconvulsive therapy
E- mirtazapine

MCQs

Previous exams questions

5) Diagnostic criteria for borderline personality disorder include all the following except:
A- excessive efforts to avoid abandonment
B- disturbance in and uncertainty about self-image, aims and internal preferences
C- liability to become involved in intense and unstable relationships
D- recurrent threats or acts of self-harm
E- chronic feeling of low mood and depression

6) According to DSM-IV, for a mixed manic episode, criteria for both major depressive disorder and mania should be present for :
A- one day
B- one week
C- one month
D- three days
E- two months

7) A 55 year old lady who lives on her own, wears odd cloths and pokes around in her neighbor's garbage. She claims to have psychic powers but doesn't repeat hearing voices. What is the most likely diagnosis:
A- schizoid personality disorder
B- schizotypal personality disorder
C- avoidant personality disorder
D- paranoid personality disorder
E- Asperger syndrome

8) All the following statements regarding cyclothymic disorder are true except:
A- symptoms must be present for at least 2 years
B- occurs at the same rate among men and women
C- symptoms satisfy major depressive disorder
D- patient don't return to baseline for more than 2 months
E- mood swings appears to the individual as not related to life events

MCQs

Previous exams questions

9) All the following personality disorders are cluster B except:
A- narcissistic
B- antisocial
C- borderline
D- obsessive compulsive
E- histrionic

10) Which of the following is true:
A- withdrawal symptoms are needed for a diagnosis of dependence
B- withdrawal is seen only when the substance used is stopped
C- the signs and symptoms of withdrawal are same for all drugs
D- the severity of withdrawal is not related to the amount of substance used
E- the severity of withdrawal is related to the duration and pattern of use

11) Which one of the following is not complication of amphetamine use:
A- hypotension
B- weight loss
C- depression
D- paranoid psychosis
E- mania

12) Which of the following substances causes the highest number of death:
A- alcohol
B- nicotine
C- cocaine
D- marijuana
E- heroin

13) Who is the Father of psychiatry: (MCQ 2022)
A- Emil Kraepelin
B- Eugen Bleuler
C- Sigmund Freud
D- Kurt Schneider
E- Erik Erikson

MCQs

Previous exams questions

14) Characteristic feature of delirium include:
A- grandiose delusions
B- clouding of consciousness
C- thought insertion
D- compulsive behavior
E- thought withdrawal

15) Flight of ideas:
A- characteristic of a depressive disorder
B- due to rapid fluctuation of mood
C- diagnostic feature of manic episode
D- an early sign of dementia
E- non of above

16) Delirium Tremens is a complication of:
A- Amphetamine abuse
B- Alcohol withdrawal
C- Cannabis abuse
D- Opiate Abuse
E- Alcohol intoxication

17) Incidence refers to:
A- number of all cases in a population
B- number of new cases in a population over a period of time
C- Prevalence of cases
D- admission rate of new cases
E- non of above

18) Akathisia is:
A- a positive psychotic symptom
B- a side effect of alprazolam
C- a subjective feeling of restlessness
D- a negative psychotic symptom
E- a jerky movement

MCQs

Previous exams questions

19) A medical student finds it hard to follow a patient's train of thought because he gives very long, complicated explanations and many unnecessary details before finally answering the original questions. In his report, the medical student writes that the patient displayed:
A- Loosening of association
B- circumstantialities
C- echolalia
D- neologisms
E- flight of ideas

20) Features of childhood autism include all of the following EXCEPT:
A- distractibility
B- occurrence before age 3 years
C- poor eye contact
D- poor communications
E- speech difficulty

21) All of the following are indications for antipsychotic medications except:
A- acute schizophrenia
B- mania
C- obsessive compulsive disorder
D- violent patient
E- psychotic depression

22) Which of the following is under conscious control:
A- conversion disorder
B- somatization disorder
C- body dysmorphic disorder
D- factitious disorder
E- hypochondriasis

MCQs

Previous exams questions

23) 34-year-old woman presented with low mood, insomnia, weight loss and loss of interest for the last 4 months. She was diagnosed as depression and given antidepressant drugs for a reasonable period and optimum dose without achieving remission.
The most appropriate laboratory test for this patient is:
A- CT brain
B- serum folate
C- TFT “thyroid function test”
D- HCG “human chorionic gonadotropin” level
E- serum prolactin

24) 24-year-old man is admitted to the inpatient psychiatry unit after his mother observed him standing in place for hours at a time in abnormal postures. During his exam, the patient stands with one arm raised directly above his head and the other straight out in front of him. He is mute, does not appear aware of his surroundings, and actively resists any attempts to change his position.
Which of the following best describes the patient’s behavior:
A- apraxia
B- dystonia
C- tardive dyskinesia
D- catatonia
E- dissociation

25) Features of bulimia nervosa include all of the following except:
A- enlarged parotid gland
B- purging
C- dental caries
D- severe weight loss
E- induced vomiting

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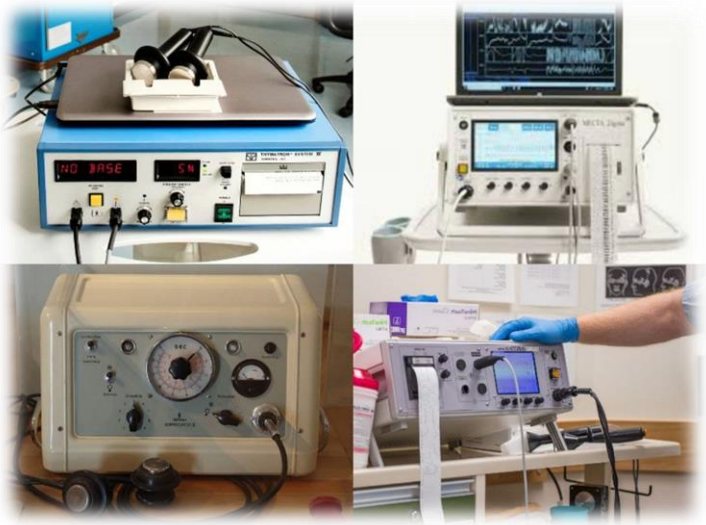
OSPE Questions

AlNeelain Exam 2022 OSPE questions:

1) Look for this picture and answer:



1. What is this device? **ECT = Electro convulsive therapy**

2. Give one preparation before use it? **General anesthesia**

Other preparation include: Medical history, Physical Examination, Investigation , CXR, ECG, Consent and use unilateral bilateral electrode.

3. What are indications to use it?

- **Severe depression**
- **Depression with psychosis**
- **Catatonia**
- **Pregnancy, Post partum depression or psychosis**
- **Refuse to eat, Resistant of ttt**
- **Highly suicidal risk or suicidal attempt**
- **Neuroleptic malignant syndrome.**

4. Give one complication for it? **Anterograde or retrograde amnesia**

5. What are absolute contraindications of it? **NO absolute contraindications**

6. What are contraindications of it?

Cerebral aneurysm, increase Intracranial pressure, Recent MI, Arrhythmia, Impending retinal detachment and Highly anesthetics risk.

OSPE Questions

AlNeelain Exam 2022 OSPE questions:

2) This collection of screenshots take from a video in which a strangely dressed woman speaks a lot at a fast pace, showing increased movement and activity.

1. What you see?

Agitated woman, talk too much

2. What is your diagnosis? **Mania**

3. What is the clinical presentation of your diagnosis?

DIG FAST → Distractibility, Irresponsibility, Grandiosity, Flights of ideas, Agitation, Sleep less, Talk too much, pressure speech

4. What is the treatment of this case?

Lithium, Haloperidol, IV Benzodiazepines for acute phase, ECT and CBT

OSPE Questions

AlNeelain Exam 2022 OSPE questions:

3) This collection of screenshots take from a video in which A man in shabby clothes, walking alone in the street, suddenly appears to pick up a stone from the ground, hit a man on his bicycle and knock him to the ground, then proceeds as if nothing had happened.

1. Describe what you see?

A shabby man suddenly exhibits aggressive behavior

2. What is the appropriate diagnosis? **Schizophrenia**
3. Give differential diagnosis. **Schizoid personality disorder!**
4. What is the clinical presentation of your diagnosis?

delusions, auditory hallucinations, disorganized or catatonic behavior, disorganized speech, Avolition, Anhedonia, Asocialy, Alogia

5. Outline the management.

Antipsychotics as haloperidol, CBT,
Family therapy and social rehabilitation

OSPE Questions

AlNeelain Exam 2022 OSPE questions:

4) Look for this picture and answer:

1. What does this picture represent (diagnosis!)?

Catatonia

2. What are the diseases accompanied whit this case?

Depression, Bipolar & Schizophrenia

3. What is the clinical presentation of your diagnosis?

Immobility, Stupor or mutism, Negativism, Catalepsy, Posturing, Echolalia and Echopraxia

4. How to treat this patient?

Benzodiazepine & ECT

Note: avoid antipsychotics

OSPE Questions

AlNeelain Exam 2022 OSPE questions:

5) This collection of screenshots take from a video shows a man entering the room and sitting in front of a bottle of alcohol, while **listening to two people talking badly about him**.

1. How to describe this case?

3rd person auditory hallucination

2. Which psychiatric condition related to this case?

Schizophrenia & alcohol use disorder

6) Look for this picture and answer:

1. What is this drug?

Citalopram

2. What is the group of this drug?

SSRI = Selective serotonin reuptake inhibitors

3. What are indications to use it?

GAD, Panic disorder, MDD …etc

4. What are side effects?

Sexual dysfunction, headache, insomnia, GIT upset …etc

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Short Test

You have only 30 minuets, Try to answer by yourself , then compare your performance with the answers below

First Question: Select the one best answer:-

One Mark for each question

1) Which of the following personality disorder is social phobia most likely confused with:

A. avoidant
B. dependent
C. schizoid
D. Paranoid
E. histrionic

2) A psychiatric patient who, although coherent, never gets to the point has a disturbance in the form of thoughts, called:

A. word salad
B. circumstantially
C. verbigeration
D. blocking
E. tangentiality

3) Feeling unfamiliarity with a familiar situation is known as :

A. Jamis vu
B. Deja pense
C. confabulation
D. Deja vu
E. Deja entendu

4) A 23-year-old woman arrives at the emergency room complaining that, out of the blue, she had been seized by an overwhelming fear, associated with shortness of breath and a pounding heart. These symptoms lasted for approximately 20 minutes, and while she was experiencing them, she feared that she was dying or going crazy. The patient has had four similar episodes during the past month, and she has been worrying that they will continue to recur. Which of the following is the most likely diagnosis:

A. acute psychotic episode
B. Hypochondriasis
C. Panic disorder
D. Generalized anxiety disorder
E. Posttraumatic stress disorder

Short Test

5) Which of the following statements concerning ADHD is correct?

A. it is more common in boys
B. stereotypy is common
C. social isolation is common
D. onset is at age of 10
E. there is an increased incidence in social high class

6) The following drug is used in the treatment of nocturnal enuresis:

A. citalopram
B. imipramine
C. carbamazepine
D. promethazine
E. propranolol

7) Which of the following is a negative symptom of schizophrenia?

A. though reading
B. avolition
C. visual illusion
D. hostility
E. delusions

8) Contraindications of ECT include:

A. pregnancy
B. epilepsy
C. elderly
D. cerebral tumour
E. diabetic patients

9) the most common cause of amnestic syndrome is:

A. Alzheimer disease
B. concussion
C. hypoxia
D. intracranial infarction
E. vitamin deficiency

10) Among persons who commit suicide; the most frequent diagnosis are major depression &:

A. borderline personality
B. alcoholism
C. dementia
D. Schizophrenia
E. Somatization disorder

Short Test

Second Question: Read the following and answer:-

1) A 20-year-old man presented with the chief complaint of persistent desire to count things and numbers wherever he goes , in spite that he knows it is senseless and it is his own thinking so he used to resist and this resistance led to an intense anxiety.

1. What psychopathology is this man having?

8 Marks

……

2. What is the most likely diagnosis?

……

3. What is the 1st line of treatment you can describe for this man?

……

4. Which psychotherapy can be useful for this case?

……

2) A 30- year old married male Sudanese has 2 years history of gradual onset of social withdrawal and decreased emotional responsiveness. Recently he started to believe that his food is being poisoned and he will chock and also his food is pureed. He has lost weight and he started to neglect his personal hygiene. He has no history of substances abuse.

1. What is the most likely diagnosis?.

4 Marks

……

2. Choose the correct one: This man displays:

A. persecutory delusion
B. ideas of reference
C. an overvalued ideas
D. 2nd person hallucination
E. Depersonalization

3) A 17 year Sudanese girl is brought to emergency room by her parents because of sudden blindness. The patient is from an intensely religious background. She states that she cannot see anything, and she believe her condition is divine punishment for her sinful behavior. She also states that she gracefully accepts “Gods will”. Physical examination shows intact visual reflex.

1. What is the most likely diagnosis?

4 Marks

……

2. Outline the management.

……

Short Test

Third Question: look for the pictures and answer:-

Picture 1:

8 Marks

1. What is the name of this abnormality?

……

2. What is the most likely diagnosis?

……

3. What are other signs is your diagnosis may be presented with?

……

……

4. What is appropriate treatment?

……

Picture 2:

6 Marks

1. What is the most severe withdrawal manifestation of this substance?

……

2. Give 3 clinical features result of intoxication of this substance?

……

……

……

3. Give one long-term complications result of this substance abuse?

……

Short Test

ANSWERS

WHAT IS YOUR FINAL SCORE? | | **40** |

How many questions did you get correctly? How long did it take you for that?

First Question: Select the one best answer:-

Question	1	2	3	4	5	6	7	8	9	10
Answer	A	E	A	C	A	B	B	D	A	B

Full correct answers = 10 Marks

Second Question: Read the following and answer:-

1) **1 : Compulsion**
   2 : OCD
   3 : SSRI as citalopram
   4 : CBT and/or ERP

2) **1 : Schizophrenia**
   2 : A = persecutory delusion

3) **1 : Conversion disorder**
   2 : CBT, Hypnosis, Stress management, Physical therapy, Occupational therapy, Speech therapy, Medications to treat the medical conditions.

Full correct answers = 16 Marks

Third Question: look for the pictures and answer:-

Picture 1:
1 : Catatonia
2 : Catatonic Schizophrenia
3 : Immobility, negativism, catalepsy, posturing, echolalia and echopraxia
4 : ECT and Benzodiazepine

Picture 2:
1 : Delirium tremens
2 : Slurred speech, incoordination & steady state.
3 : Wernicke's encephalopathy

Full correct answers = 14 Marks

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تم بحمد الله وتوفيقه . .

دعواتكم لي ولوالديّ ❤

مصعب عماد المبيض

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